

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

THE UNITED STATES OF AMERICA PLAINTIFF
VS. CIVIL NO. 3:16CV00622CWR-FKB
THE STATE OF MISSISSIPPI DEFENDANTS

VOLUME 10

BEFORE THE HONORABLE CARLTON W. REEVES
UNITED STATES DISTRICT JUDGE
MORNING SESSION
JUNE 12, 2019
JACKSON, MISSISSIPPI

REPORTED BY: BRENDA D. WOLVERTON, RPR, CRR, FCRR
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MS. HALEY VAN EREM
3 MR. JORGE CASTILLO
MR. PATRICK HOLKINS

4 FOR THE DEFENDANT: MR. JAMES W. SHELSON
5 MR. REUBEN V. ANDERSON
MR. HOWARD DAVID CLARK III
6 MS. MARY JO WOODS

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1 THE COURT: Good morning. I apologize for the delay.
2 I was ready to come out. I got a call at 9:00 o'clock that I
3 had to take care of.

4 Housekeeping matters. Is there anything we need to --
5 Ms. Rush has something for me. Going to be spot on today.
6 Right? I'm just -- we try to --

7 MS. RUSH: Your Honor, I did want to give you a road
8 map of the day.

9 THE COURT: Okay.

10 MS. RUSH: We are -- our first witness will be Sheriff
11 Travis Patten, followed by Dr. Judith Baldwin, one of our
12 experts in our clinical review. And if we have time, we will
13 get started on Katherine Burson, another expert from our
14 clinical review.

15 THE COURT: Okay. Thank you.

16 Well, let me -- when we scheduled this matter, and I
17 know the parties have been working to -- you know, to sort of
18 maybe in response to some of the things that the court has been
19 saying, I do not want either party to feel like you are not --
20 I don't want you to abdicate your responsibility of putting on
21 the case that you wanted to put on. In no way am I suggesting
22 or trying to interfere with you changing or truncating your
23 case in such a way that you do not make your record in the way
24 that you wanted to make it. I mean, I cajole you and sort of
25 suggest to you and all of that, but I do not want the parties

1 to feel like the judge is somehow interfering with our ability
2 to put on the case that we wanted to put on. I'm not doing
3 that.

4 MS. RUSH: We appreciate that, Your Honor. And we
5 appreciate all of your suggestions. But we feel like we have
6 just been able to move a little bit faster than we anticipated.
7 But we appreciate it. Thank you.

8 THE COURT: Okay. All right. For other logistical
9 housekeeping things, I know on the front end, one of the --
10 maybe that was at the pretrial conference we were talking about
11 post trial briefing, the possibility, the request for the
12 government -- I have two governments here. I don't need to
13 ignore my own state government. But the United States had a --
14 sort of laid the predicate that it might ask for a number of
15 weeks to do post trial briefing.

16 And as we -- as you think about your case, I will let
17 you know that I do not intend to give a whole lot of time to do
18 the post trial briefing. So as you think about how your case
19 is progressing and on how you are doing it, I think -- I think
20 the suggestion was maybe a minimum or a maximum of 60 days or
21 something like that, I believe, as I recall. I am highly
22 inclined not to do that amount of time. I think the issues are
23 front and center. I think -- I don't know if I will need all
24 of that time to digest what I'm hearing and what is going on,
25 so as you're thinking about how your case is evolving, and this

1 is for everyone, I do not think I will -- I don't want to
2 delay. That's my thing. I don't want to unnecessarily delay a
3 final ruling on this for very long. So, you know, if I do 60
4 days, that means, you know, that could possibly mean, you know,
5 way into the fall, and I just don't want to do that.

6 Ms. Rush.

7 MS. RUSH: Thank you, Your Honor. It would be helpful
8 for us to have a sense, if the court has a preference already,
9 of what kind of post trial findings and filings that the court
10 would prefer. We would expect a post trial findings in fact
11 and conclusions of law and potentially a post trial brief,
12 but -- if the court would find that helpful. But that would
13 help us plan --

14 THE COURT: Right. That's --

15 MS. RUSH: -- for timing if you have a sense -- sorry.

16 THE COURT: I'm sorry. I mean, that's what I would
17 want, post trial findings of fact, conclusions of law. And
18 that's all. But I guess what I was alluding to, I did not --
19 I'm likely -- instead of a 60-day turnaround to do it, it may
20 be like 14 days or something like that. I mean, it may be a
21 quick turnaround as far as the parties submitting anything
22 because of what I need to do and how soon I need to get it done
23 based on my other obligations in the late summer and fall and
24 winter and staffing and all of that. So that's what I'm
25 concerned about. So it would be, you know, findings of fact,

1 conclusions of law.

2 The one advantage everyone has here, unlike in most
3 cases, is that we are getting daily transcripts now already, so
4 the record will be done on the day that the trial ends already.
5 You won't have to wait around for a record. So it will be
6 proposed findings of fact, conclusions of law, and I do -- you
7 know, I know the parties would want to have sufficient time. I
8 just do not believe that that time will exceed more than two
9 weeks. I don't know yet, but I don't think it would exceed --
10 only because of how it might impact on what I need to get done.
11 That's all.

12 MS. RUSH: We will be ready. Thank you, Your Honor.

13 THE COURT: All right. Okay. The government has all
14 the resources in the world. They can get it done. And I say
15 that to both governments.

16 Is there anything else we need to take up before we
17 call our next witness?

18 MR. SHELSON: Your Honor, just in response to that,
19 the State's position is that conclusions of law and findings of
20 fact make sense, and that, separate from that, a brief, a post
21 trial brief would not be necessary. That's our position.
22 We're fine with whatever time the court has in mind and we
23 think that reasonable page limits would also be in order.

24 THE COURT: Oh, yeah, it will be.

25 MR. SHELSON: Thank you, Your Honor.

1 THE COURT: All right. Yes. And my view of
2 reasonable may just line up with the parties' view of
3 reasonable as well. Thank you, Mr. Shelson.

4 Is the United States ready to call its next witness?

5 MR. CASTILLO: Yes, Your Honor.

6 THE COURT: You may proceed.

7 MR. CASTILLO: Good morning, Your Honor.

8 THE COURT: Good morning.

9 MR. CASTILLO: Jorge Castillo for the United States.
10 The United States calls Sheriff Travis Patten as its next
11 witness.

12 THE COURT: All right.

13 **TRAVIS PATTEN,**
14 having first been duly sworn, testified as follows:

15 THE COURT: Get comfortable, Sheriff Patten. You're
16 in the hot seat now. It looks like that seat is wobbling in
17 some way. But if you're fine, that's good.

18 Just speak directly into the microphone. Try to speak
19 at a pace at which the court reporter can keep up with you.
20 Allow the attorneys to finish their question or statement
21 before you begin to speak so that the two of you will not be
22 speaking at the same time and just make sure all your responses
23 are verbal, please.

24 So for the record, could you please state and spell
25 your name?

1 THE WITNESS: My name is Travis Patten, T-R-A-V-I-S,
2 P-, as in Paul, A-T-T-E-N.

3 THE COURT: Thank you.

4 You may proceed.

5 And you are doing great. That's -- the volume and
6 everything is great.

7 Go ahead.

8 DIRECT EXAMINATION

9 BY MR. CASTILLO:

10 Q Good morning, Sheriff.

11 A Good morning.

12 Q As I'm sure you know, I'm going to ask you several
13 questions today. For the purpose of this trial, the relevant
14 fact period goes up through December 31st, 2018. I'm going to
15 ask that your answers focus on that time period. Okay?

16 A Yes.

17 Q Sheriff, what is your current job?

18 A Sheriff of Adams County, Mississippi.

19 Q How long have you been the Adams County sheriff?

20 A Since January 4, 2016.

21 Q What part of the state is Adams County in?

22 A Southwest Mississippi.

23 Q And broadly speaking, what are the responsibilities of the
24 sheriff of Adams County?

25 A Criminal patrol, criminal investigation. We serve civil

1 process. We seize property, sell property. We're over the
2 courthouse. We're over the jail. And we do a lot of civil
3 commitments as well.

4 Q You mentioned you run a jail. Where is that jail located?

5 A It's 306 State Street.

6 Q Where is that in relation to your main sheriff's office?

7 A It's in the same building.

8 THE COURT: And that's in Natchez? You mentioned
9 Adams County. I don't think you --

10 THE WITNESS: Yes. The city of Natchez, Adams County.
11 It is in the city limits of Natchez.

12 THE COURT: Okay. Thank you.

13 BY MR. CASTILLO:

14 Q Do you hold people in your jail who haven't been charged
15 with a crime?

16 A Yes, we do.

17 Q And why are they there?

18 A Civil commitments.

19 Q Does a mobile crisis team serve Adams County?

20 A There is a mobile crisis team that's supposed to serve
21 Adams County, but we don't ever see them.

22 Q Is there a crisis stabilization unit or a CSU in Adams
23 County?

24 A No.

25 Q Who do the people of Adams County call in a mental health

1 crisis?

2 A The Adams County sheriff's office.

3 Q Is that a problem?

4 A It is.

5 Q Have you voiced your concerns about this problem with
6 anybody in the State?

7 A Yes, I have.

8 Q With whom?

9 A Brent Hurley.

10 Q Have you spoken with other sheriffs about this issue?

11 A Yes, I have.

12 Q Have you told any other sheriffs that you are testifying in
13 this case?

14 A I just told the president of the Sheriffs Association
15 yesterday that I was testifying in this case, and he was glad
16 that I was because he said we all need this help.

17 Q Let's talk about the civil commitment process for persons
18 with mental illness in Adams County for a minute. What's the
19 sheriff's office role in a civil commitment process?

20 A Basically what we do is we pick them up after a commitment
21 has been issued. We make sure that we get them to the hearing
22 on time. Once the hearing is done, if they are committed, we
23 transport them to wherever the court has deemed that they need
24 to go. If it's outpatient, you know, we release them. But in
25 the meantime, if that hearing is a day or two off, we actually

1 hold them in the jail until we can get them there.

2 Q And for the people you transport to an inpatient facility,
3 who picks them up?

4 A We do.

5 Q Do you hold people in jail while they're going through this
6 process?

7 A Yes, we do.

8 Q Where do you hold them?

9 A We have two holding cells that we retrofitted with a thick
10 padding that we hold them in in our jail.

11 Q You said they are retrofitted. What were these cells
12 designed for?

13 A They were designed as more of your drunk tanks and for
14 people who were combative, people who were coming off of drugs,
15 things of that nature, but they were not originally designed to
16 be mental health -- for mental health patients.

17 Q Could you describe these holding cells for us?

18 A They are about a 7-by-8, approximately 7-by-8 cell. They
19 don't have beds in them or anything like that. The only thing
20 they have is a toilet and a sink and thick padding all over.

21 Q I would like to show you some pictures.

22 MR. CASTILLO: Your Honor, may I approach?

23 THE COURT: Yes, you may.

24 BY MR. CASTILLO:

25 Q (Tenders documents.) Sheriff Patten, I just handed you

1 three documents, Plaintiff's Demonstrative Exhibits 13, 14 and
2 15. Are these pictures of the commitment cells?

3 A Yes, they are.

4 MR. CASTILLO: Your Honor, we present these for
5 identification purposes.

6 THE COURT: All right.

7 (EXHIBITS PDX-13, PDX-14 AND PDX-15 MARKED FOR
8 IDENTIFICATION)

9 BY MR. CASTILLO:

10 Q Looking at these pictures, I don't see a bed. Where do
11 people sleep when they're in the commitment cell?

12 A We give them a mattress and they sleep on the floor.

13 Q If you look at Number 13, Plaintiff's Demonstrative
14 Exhibit 13 and 14, there is something on the floor. What is
15 that?

16 A If you look at the center, picture 13 here, you'll see that
17 hole is -- that's an actual drain. And if you look around the
18 edges of that drain, you can see -- you can kind of see how
19 thick the padding is that we had to put in there. If you look
20 to the right of that where it's kind of awkwardly shaped, that
21 happened when one of our mental health consumers were chewing
22 on the padding.

23 Q How many people can be held in these commitment cells?

24 A One.

25 Q And how many do you have?

1 A Two.

2 Q Have you ever needed to hold more than two people who are
3 suffering a mental health crisis?

4 A Absolutely.

5 Q Where do they go?

6 A What we have to do then is we take them upstairs and we
7 have to clear out a regular cell. And we put them in there and
8 we have to put a 24-hour, seven-day-a-week watch on them, guard
9 on them watching that cell. Because these cells here
10 (indicating) are equipped with cameras inside the cells. The
11 ones upstairs are not.

12 Q How often do you need to use an overflow space to hold
13 people in mental health crises?

14 A It's quite often. Because, again, these cells are not just
15 for the mentally ill.

16 Q I would like to show you some more pictures.

17 MR. CASTILLO: Your Honor, may I approach?

18 THE COURT: Yes, you may.

19 BY MR. CASTILLO:

20 Q (Tenders documents.) Sheriff Patten?

21 A Yes.

22 Q What are the pictures that I just handed you?

23 A These are two of the cells upstairs in our jail that we
24 clear out when we have an overflow in those two holding cells.

25 MR. CASTILLO: Your Honor, these images are

1 Plaintiff's Demonstrative Exhibits 16 and 17 which we offer for
2 identification purposes.

3 THE COURT: Okay. Any objection from the State? I
4 did not ask that with respect to the 13, 14, 15. Was there any
5 objection as to PDX-13, 14, 15?

6 MR. CLARK: No objection, Your Honor.

7 THE COURT: Okay. And 16, 17?

8 MR. CLARK: None.

9 THE COURT: Okay. Thank you. They will be marked for
10 identification.

11 (EXHIBITS PDX-16 AND PDX-17 MARKED FOR IDENTIFICATION)

12 BY MR. CASTILLO:

13 Q Do these overflow cells have any padding?

14 A No.

15 Q Were they designed for holding people in mental health
16 crisis?

17 A No.

18 Q Do the persons that you pick up for a commitment hearing
19 wait in jails for that hearing?

20 A Yes, they do.

21 Q And do they wait in jail after a hearing before they are
22 admitted to a treatment facility?

23 A If there is not a bed readily available, yes, we hold them
24 until we can get them transported.

25 Q And how long does that process from picking them up to

1 getting them to a treatment facility take?

2 A It can take anywhere from 24 to 48 hours to a week and a
3 half. Minimum 24 to 48, max about a week and a half sometimes,
4 depending on bed availability.

5 Q Are these people receiving any mental health treatment
6 during their time in the jail?

7 A No.

8 Q Is there a local community mental health center that's near
9 the jail?

10 A It is.

11 Q What organization?

12 A Southwest Mental Health.

13 Q And where are they located?

14 A Directly across the street, about 10 to 12 feet across the
15 street from the sheriff's office in Natchez, Mississippi.

16 Q When you transport people to a commitment hearing and to
17 inpatient facility treatment, what vehicles do you use?

18 A We have a transport van that is equipped with cameras.

19 Q Are you always able to use that transport van?

20 A No, because sometimes we have more than one committal that
21 needs to be transported. So if that van is on a trip to
22 Meridian, I have to pull somebody off the street and put them
23 in a patrol car and send them to wherever they need to go.

24 Q You said sometimes. How often?

25 A It's quite often. Because you've got to look -- if we're

1 taking a trip to Meridian or the Coast, and that van is gone,
2 it's not going to be back within eight hours. So it happens
3 more than we need it to happen.

4 Q Are the persons you're transporting handcuffed?

5 A Yes, they are.

6 Q Based on your observations, what is your impression of what
7 it's like in the jail for the people who are being civilly
8 committed?

9 A You know, when you look into those people's eyes who are
10 being civilly committed, when you look into the eyes for a
11 normal man to hear the clink of that cell close, it does
12 something to your psyche. So for the ones who have a
13 heightened sense of fear, it is pure terror.

14 Q How do you feel about this?

15 A I feel like they don't need to be in my jail or anybody's
16 jail.

17 Q I want to focus now on your office work with people who
18 have serious mental illness outside of the civil commitment
19 process. Do you have staff who have been assigned to work with
20 people on these cases?

21 A Yes, we have a team that is trained in CIT. CIT team.

22 Q What does CIT stand for?

23 A Crisis intervention team.

24 Q And how many officers do you have trained in CIT?

25 A Three.

1 Q What sort of training do they go through?

2 A They went through the 40-hour CIT training course. They
3 have been to training for the -- dealing with the mentally ill,
4 first aid training. They went to the training, the trainer
5 course for citizens with special needs. They've also been
6 through human behavior and conflict management training.

7 Q Do these --

8 A Deescalation as well. I'm sorry. Deescalation as well.

9 Q How many do you have, again?

10 A Three.

11 Q And do these three officers work strictly with persons
12 having mental health crises?

13 A No, they do not.

14 Q Who else do they work with?

15 A They work with victims of crimes.

16 Q What triggers a response from the officers trained in CIT
17 to a scene where there is someone having a mental health
18 crisis?

19 A Basically it could be a call from the parents or loved ones
20 who already know that that person is mentally ill because we
21 have dealt with them before, or it could be our supervisors on
22 the street who recognize the signs that this is not somebody
23 who needs to go to jail, this is somebody who is having a
24 mental health crisis and we need CIT team called out.

25 Q Are your CIT-trained officers mental health clinicians?

1 A No, they're not.

2 Q Can your CIT-trained officers call clinicians when their
3 training is not sufficient to diffuse a mental health crisis?

4 A We tried that before. It didn't work too well. No.

5 Q Will Region 11's mobile crisis team come provide
6 stabilization services?

7 A I haven't seen them since I have been there.

8 Q Where is Region 11's mobile crisis --

9 A McComb, Mississippi.

10 Q Which county is that?

11 A Pike County.

12 Q And how far is that from Adams County?

13 A It is about an hour away.

14 Q What is your understanding about why they don't respond to
15 your county?

16 A To me, my understanding would be that they are already
17 overwhelmed with the cases they're dealing with over there. We
18 tried in 2016 and 2017, but it's just not feasible for to think
19 that if they've got a crisis in Madison or somewhere else, that
20 they're going to be able to respond to Adams County to a crisis
21 that's happening now. And when you have officers on scene who
22 have to respond within 15 minutes, it's like an eternity when
23 you're dealing with somebody that's out of control. So it just
24 doesn't work. They have actually called us and asked us to go
25 deal with situations.

1 Q What do you mean by that, someone calls mobile crisis?

2 A Yes. Some people have called mobile crisis, and mobile
3 crisis, because they know I have CIT-trained officers, have
4 asked them to go and deal with it. And we have, because that's
5 the people we serve.

6 Q You have a binder in front of you. I would like to -- you
7 to turn in your binder to Plaintiff's Exhibit PX-415 which has
8 been previously admitted into evidence. This map shows the
9 rate of mobile crisis response per capita by CMHC region. The
10 dark red areas have high rates of mobile crisis utilization and
11 the light red or pinkish areas are where there is low rates of
12 mobile crisis utilization. Do you see Adams County on this
13 map?

14 A Yes, I do.

15 Q Does it appear that Region 11 has a high or a low ratio of
16 crisis responses relative to other regions?

17 A We have an extremely low.

18 Q Is this consistent with your experience?

19 A Yes.

20 Q Back to your binder. If you can turn to joint Exhibit 52.
21 And using the numbers on the bottom right of the document, turn
22 to page 5. This has been previously admitted into evidence.
23 This is the Department of Mental Health's annual report for
24 fiscal year 2015. In this page it discusses mobile crisis
25 response teams. I want to focus your attention on the first

1 paragraph. I'm just going to read it:

2 "Mobile crisis response teams provide community-based
3 crisis services that deliver solution-focused and
4 recovery-oriented behavioral health assessments and
5 stabilization of crisis in the location where the individual is
6 experiencing the crisis. Mobile crisis response teams work
7 hand in hand with the local law enforcement, chancery judges
8 and clerks and the crisis stabilization units to ensure a
9 seamless process."

10 Would you describe your experience with mobile crisis as
11 working hand in hand?

12 A No.

13 Q Is mobile crisis -- is there a mobile crisis team providing
14 assessments and stabilization services in the location where
15 the individual is experiencing the crisis in Adams County like
16 it's described here?

17 A No.

18 Q As sheriff of Adams County, would you like a mobile crisis
19 response team to provide crisis services with or instead of the
20 sheriff's office?

21 A Absolutely.

22 Q Staying with this document, if you can turn to page 13,
23 again using the numbers on the bottom right. I'm sorry. Page
24 14, using the numbers on the bottom right, where it says crisis
25 intervention teams. Do you see that?

1 A Yes.

2 Q Would you please read the -- will you please begin reading?
3 And I will tell you to stop when it's time.

4 A "Crisis intervention teams are partnerships between local
5 law enforcement agencies and a variety of agencies, including
6 community mental health service centers, primary health
7 providers, advocacy groups such as NAMI, and behavioral health
8 professionals. Officers joining a team learn the skills they
9 need to respond to people experiencing a mental health crisis
10 and divert them to an appropriate setting for treatment,
11 ensuring people are not arrested, taken to jail due to symptoms
12 of their illness."

13 Q Thank you. Do your CIT-trained officers have a partnership
14 with the local community mental health center and other
15 behavioral health professionals when it comes to responding to
16 people in mental health crises?

17 A No.

18 Q Are you a mental health clinician?

19 A No.

20 Q Is there a place where your CIT-trained officers can divert
21 people who are experiencing crisis so they don't have to go to
22 jail?

23 A No.

24 Q Again sticking with joint Exhibit 52 and turning to page 22
25 using the numbers on the bottom right, do you see this map?

1 A Yes.

2 Q This map shows the CSUs that existed in Mississippi as of
3 July 2018. Is there a CSU anywhere in Region 11?

4 A No.

5 Q In 2018, did a CSU open in Adams County?

6 A No.

7 Q Would you like a CSU to open in Adams County?

8 A Absolutely.

9 Q Why is that?

10 A Because it's tasking for us when we have to take somebody
11 as far as we do and actually have to go through the process of
12 getting them committed, when some of them may not need to be
13 committed. Some of them may be able to get stabilized right
14 here at home. So --

15 Q CSUs provide crisis services. In Adams County, do you
16 believe that there is a need for services that could prevent
17 mental health crises from happening in the first place?

18 A Yes, I do.

19 Q I want to get into the numbers for a minute. On average,
20 how many people go through the civil commitment process in
21 Adams County?

22 A On average, we have an average of about -- I would say
23 about eight a month committals.

24 Q Could you please turn to page 21 of the DMH annual report
25 for fiscal year 2018? This is a breakdown of the adult

1 psychiatric admissions by county to the state hospitals during
2 that time. Do you see Adams County?

3 A Yes.

4 Q Where does Adams County appear to fall in civil commitments
5 to Mississippi State Hospital?

6 A They appear to fall behind Hinds County and Rankin County
7 to the Mississippi State Hospital.

8 Q So third behind Hinds and Rankin?

9 A Yes.

10 Q How does Adams County population stack up against Hinds and
11 Rankin County?

12 A We are probably a fifth of the size of Hinds and Rankin
13 County population-wise.

14 Q Of the people who are committed to the state hospitals, are
15 you seeing any people being repeatedly committed?

16 A Yes.

17 Q And for those people with repeat admissions, what are you
18 seeing after they go to the state hospital?

19 A You know, when we go pick them back up and they have been
20 stabilized, what we are seeing is they are thinking they are
21 okay permanently and they're not taking their medication or
22 they don't have the insurance that they need to stay on their
23 medication, and they don't have the support they need to keep
24 encouraging them to stay on it. So we see them begin to
25 self-medicate, but some of them even try to work the system.

1 So that's what we're seeing quite often.

2 Q And what happens that you are seeing them again in a
3 commitment process?

4 A Basically what happens again is the family or their loved
5 ones are at their wit's end. They are calling me again because
6 they can't control their loved ones. Even though they love
7 them, they can't control them. So commitments are being issued
8 again and we're back picking them up and going through the
9 hearing process and sending them right back up there.

10 Q If there was in Adams County someone to receive these
11 people cycling and offer them help with mental illness
12 symptoms, --

13 THE COURT REPORTER: I'm sorry.

14 MR. CASTILLO: Yes, ma'am. I'm sorry. I went too
15 fast there.

16 BY MR. CASTILLO:

17 Q If there was someone in Adams County to receive these
18 people who are cycling and offer them help with mental illness
19 symptoms, do you think that would make a difference?

20 A I think if they could keep their hands on some of them, I
21 think it absolutely would make a difference.

22 MR. CASTILLO: If I can just have one second to
23 confer?

24 THE COURT: Okay.

25 (SHORT PAUSE)

1 BY MR. CASTILLO:

2 Q I just have maybe one or two questions left. Since you
3 became sheriff in January of 2016, have you seen any
4 improvements in the civil commitment rates or process in Adams
5 County?

6 A No.

7 MR. CASTILLO: No further questions.

8 THE COURT: All right. Thank you.

9 Any cross-examination of this witness?

10 MR. ANDERSON: Could you give us just two minutes,
11 Your Honor?

12 THE COURT: Yes. Uh-huh.

13 (SHORT PAUSE)

14 **CROSS-EXAMINATION**

15 BY MR. CLARK:

16 Q Good morning, Sheriff Patten.

17 A Good morning.

18 Q You testified about services you would like in Adams County
19 to see offered, and I want to clarify that. What services
20 would you like to see offered?

21 A I would love to see a mobile crisis stabilization unit
22 there. I would love to see a partnership going on between
23 possibly the State and some of our local medical clinicians
24 there. And I would love to have a crisis team that actually
25 responds, a mobile crisis team that actually responds.

1 Q Sure. Anything else?

2 A You know, if we could have a CSU, that would be great for
3 us. We need a crisis stabilization unit. We have people
4 trained to divert people to that but we need the team to make
5 sure they get there and the unit to put them in. Right now,
6 Adams County doesn't have that.

7 Q And there was some testimony about the CIT, the crisis
8 intervention team. You would agree with me that CIT is a good
9 program. Correct?

10 A I think it is a great program but I think it is a program
11 that cannot stand alone.

12 Q That cannot what? Stand alone?

13 A It cannot stand alone.

14 Q Sure. And you would agree with me that persons with mental
15 health issues need treatment. Correct?

16 A Absolutely.

17 Q And your position is in receiving that treatment, I believe
18 your words were, "They don't need to be in my jail," meaning
19 they don't need to receive that treatment in your jail?

20 A Exactly.

21 Q Okay. You would agree with me that some of those persons
22 need to be treated in a state hospital. Is that correct?

23 A The more violent ones, absolutely. And the reason I say
24 that is because when we take them to some of the private
25 facilities, if they get violent, they go on a list where they

1 can't come back. So there is a need, yes.

2 Q There is a need to be institutionalized in a state
3 hospital?

4 A Yes. Not all, but the violent ones.

5 Q Would you agree with me that there must be a collaborative
6 effort between the local centers and the state institutions?

7 A I think you need that. Certain people require certain
8 things and I think it definitely needs to be a collaborative
9 effort. Because that's what's happening. You have resources
10 here, you have resources there, but nobody is the glue between
11 them. And I think what some of the -- if partnerships are
12 formed, CSU unit put in place, and people are actually doing
13 the jobs that they are supposed to be doing, I think it could
14 work.

15 Q You think it will work?

16 A I think it could if you had a collaborative effort going,
17 yes.

18 MR. CLARK: Thank you. Nothing further. Well, one
19 second, Your Honor.

20 THE COURT: All right.

21 (SHORT PAUSE)

22 BY MR. CLARK:

23 Q Sheriff Patten, you testified a moment ago about violent
24 individuals need to receive treatment in state institutions.
25 Could you give us an example of a violent individual that you

1 have dealt with that was committed to a state hospital or that
2 needed to be?

3 A Yes. We had one guy who beat his little brother with an
4 aluminum baseball bat. He beat him pretty bad, and we couldn't
5 get any private institutions to deal with that guy because, you
6 know, he was pretty violent, so he needed to go to the State.

7 Q And did he?

8 A He went after about a year in jail. He did.

9 Q He went to the State Hospital?

10 A He did. It took us about a year to get him there.

11 Q And which state hospital was that?

12 A Mississippi State Hospital.

13 Q Okay.

14 MR. CLARK: Nothing further.

15 THE COURT: All right. For my own information, could
16 you tell me your name?

17 MR. CLARK: I'm sorry. Trey Clark.

18 THE COURT: Okay. Thank you, Mr. Clark.

19 Any redirect of this witness?

20 MR. CASTILLO: No, Your Honor.

21 THE COURT: I have a couple questions for you, Sheriff
22 Patten, and the parties will be permitted to follow up based on
23 what I have asked.

24 In giving an example, your last example, you said
25 there was a young man who stayed in your jail for a year?

1 THE WITNESS: He did, Judge. He was one of the
2 pretrial, and they wanted to see whether he could -- they
3 wanted to see was he mentally stable to stand trial. And we
4 fought and we fought and we fought to try to get that man help,
5 but it took us almost a year to get him to the State Hospital.
6 Yes, sir.

7 THE COURT: Well, did he ever go to trial or did they
8 find that he was not competent to go to trial?

9 THE WITNESS: He is still at the State Hospital.

10 THE COURT: He is still at the State Hospital now?

11 THE WITNESS: Yes, sir.

12 THE COURT: But are you telling me he stayed in Adams
13 County jail for a year?

14 THE WITNESS: We have it documented where he stayed
15 there that long. And we have it documented where we, you know,
16 made several calls to our local judges and officials telling
17 them he doesn't need to be here, he needs to go get help.

18 THE COURT: During that period of time that he was in
19 Adams County, was he in one of these -- do you remember what
20 cell he was in?

21 THE WITNESS: He was in the holding cell for the
22 longest. And then what we had to do was I actually had to hire
23 somebody. I had to go before the board of supervisors and hire
24 an extra body because we had to put him up top in an area where
25 he could be maintained where we could utilize those holding

1 cells again. I had to hire another worker, rearrange
2 schedules, everything.

3 THE COURT: You indicated, I think it was PDX-13, 14
4 and 15, these cells that are not equipped with beds. I think
5 you said that y'all put some sort of pallet or something for
6 those persons who have to stay there for more than several
7 hours or for more than a day or so.

8 THE WITNESS: Yes.

9 THE COURT: During this time that he was housed at the
10 facility, did he utilize those rooms for more than a day or
11 two?

12 THE WITNESS: He did. He utilized them for as long as
13 we could. And that's why we had to keep changing our schedule,
14 because we would put him there as long as we could hold him,
15 but when other people came in who needed them, we had to take
16 him back upstairs and put manpower right there to watch him the
17 whole time. So we got as much --

18 THE COURT REPORTER: I'm sorry.

19 THE WITNESS: I'm sorry. Where do you want me to
20 start?

21 THE COURT REPORTER: But when other people came in, --

22 THE WITNESS: But when other people came in, we would
23 move him back up top. We would have to come in. We would have
24 to schedule staff to watch him. The only time he wasn't in
25 these cells were when we didn't have other people who needed

1 those services. Otherwise, we would move him back up top and
2 have a guard there with him the whole time. And it was tasking
3 on us. That's what pushed us to keep calling the judges asking
4 them, calling the DA, "Can y'all please do something with this,
5 because he doesn't need to be here?"

6 THE COURT: Okay. You are in your first term as
7 sheriff.

8 THE WITNESS: Yes, sir, I am.

9 THE COURT: Okay. Prior to serving as sheriff, were
10 you a deputy sheriff or anything like that?

11 THE WITNESS: Yes, I was.

12 THE COURT: Okay. Well, I'm going to ask you about
13 your time as being sheriff first.

14 THE WITNESS: Yes, sir.

15 THE COURT: Are you aware of others -- well, let me
16 ask the question this way: Nobody else has stayed over there
17 while you were as sheriff for a year?

18 THE WITNESS: Not on the mental health side, no.

19 THE COURT: All right. Has anybody else stayed over
20 there more than six months while you were sheriff, on the
21 mental health side?

22 THE WITNESS: Yes, but it was tied in with the
23 criminal actions that he committed as well, and that was
24 another one that we fought to get out of there. He actually --
25 a guy came to his house, knocked on the door, and he shot the

1 guy through the door. But we knew this guy was one of those
2 repeat mental health consumers, and we knew that there is no
3 way he was going to be able to stand trial but we still had to
4 go through the process because he shot somebody through the
5 door. And so that was another one. He stayed about six
6 months. And I'm going to be honest with you, Judge, we had to
7 just recog him out. We had to recog him out.

8 THE COURT: When you say -- tell me what recog is for
9 the record.

10 THE WITNESS: Release him because he was indigent. He
11 couldn't make bond. So we recogged him out. The victim didn't
12 want to file charges on him because he knew the guy was mental,
13 and so we were able to get the charges dropped and we were able
14 to push the system to make them get him some mental health.
15 His own family wouldn't come to get him out because they were
16 afraid of him. Even when they dropped the bond extremely low,
17 the family just left him there to us.

18 THE COURT: Now, how long -- prior to being sheriff,
19 how long were you employed by the sheriff's department?

20 THE WITNESS: By the sheriff's office in Adams County,
21 I was employed eight years prior to becoming sheriff there.

22 THE COURT: And what position or positions did you
23 hold during that eight-year period?

24 THE WITNESS: I did criminal deputy. I was in the K9
25 unit. And I was a narcotics investigator as well.

1 THE COURT: Okay. As a deputy with the Adams County
2 Sheriff's Department, are you aware of any other person being
3 housed by the Adams County Sheriff's Department for a year in
4 the mental -- waiting on mental health services?

5 THE WITNESS: As a deputy, I can't say that they were
6 housed waiting on mental health services, Judge. But what I
7 can say is this: I can say, as a deputy, I have seen several
8 people who should have went through getting mental health get
9 charged with crimes just to get them off the street. And they
10 have sat there because their families wouldn't come get them.

11 THE COURT: Okay. Thank you.

12 Any follow-up based on what I have asked? I turn to
13 the United States first.

14 MR. CASTILLO: No follow-up from the United States.

15 THE COURT: All right. What about the State of
16 Mississippi?

17 MR. CLARK: Briefly, Your Honor.

18 THE COURT: Yes, sir.

19 BY MR. CLARK:

20 Q Sheriff Patten, the individual that you were speaking about
21 a minute ago that was there for you said roughly a year before
22 going to the State Hospital, it's my understanding from your
23 earlier testimony that he was arrested. Correct?

24 A He was.

25 Q He did not come to you through a civil commitment?

1 A No, he did not.

2 Q Okay. And from your testimony with Judge Reeves, I take it
3 you understand the difference between them coming to you versus
4 civil commitment and then as an arrestee?

5 A Yes, sir, absolutely.

6 Q Okay. Do you know or are you aware that the competency
7 evaluation for forensic patients --

8 THE COURT REPORTER: I'm sorry.

9 THE COURT: Slow down just a little bit, Mr. Clark.

10 BY MR. CLARK:

11 Q Are you aware that the competency evaluation for forensic
12 patients is presently under 30 days?

13 A Yes, I am.

14 Q Okay. And that the Mississippi State Hospital can't see
15 forensic patients until the records and the orders are
16 provided? Are you aware of that?

17 A I am. That's why we -- that's why we pushed letting them
18 know, "You need to get him out of here."

19 MR. CLARK: Nothing further.

20 THE COURT: All right. Is this witness finally
21 excused?

22 MR. CASTILLO: Yes, Your Honor.

23 THE COURT: All right. Mr. Patten, thank you for your
24 testimony. You may return to your normal duties.

25 THE WITNESS: Thank you, Judge.

1 THE COURT: All right.

2 MS. RUSH: May I approach, Your Honor?

3 THE COURT: You may.

4 (SHORT PAUSE)

5 MS. VAN EREM: May I proceed, Your Honor?

6 THE COURT: You may call a witness and we will wait
7 until Ms. Summers comes in to swear them in, but the witness
8 may come to the stand.

9 MS. VAN EREM: Sure. The United States calls Judith
10 Baldwin.

11 **JUDITH BALDWIN,**
12 having first been duly sworn, testified as follows:

13 THE COURT: Ms. Baldwin, were you in the courtroom
14 when I gave out the last instructions to the prior witness?

15 THE WITNESS: Yes. I just came in for a little bit.

16 THE COURT: Okay. Please make sure the lawyers finish
17 their questions before you begin to speak so that the two of
18 you will not be speaking at the same time. Speak at a pace at
19 which the court reporter can keep up with you. And make sure
20 all your responses are verbal.

21 If you will, for the record, could you state and spell
22 your name?

23 THE WITNESS: My name is Judith Baldwin. It's
24 J-U-D-I-T-H, B-A-L-D-W-I-N.

25 THE COURT: Thank you.

1 You may proceed.

2 MS. VAN EREM: Thank you, Your Honor. And my name is
3 Haley Van Erem for the United States.

4 DIRECT EXAMINATION

5 BY MS. VAN EREM:

6 Q Good morning, Dr. Baldwin.

7 A Good morning.

8 Q Dr. Baldwin, what is your occupation?

9 A I am a psychiatric mental health clinical nurse specialist.

10 Q Were you retained by the United States in this case?

11 A I was.

12 Q Did you conduct a clinical review of individuals who have
13 experienced state hospital admissions in Mississippi?

14 A I did.

15 Q Before we get into the details of your review, I would like
16 to ask you a few --

17 THE COURT: Slow down just a bit.

18 MS. VAN EREM: I'm sorry, Your Honor.

19 THE COURT: That's all right. Follow me.

20 MS. VAN EREM: I will try. I'm sorry.

21 THE COURT: That's all right.

22 BY MS. VAN EREM:

23 Q Dr. Baldwin, before we get into the details of your review,
24 I would like to ask you a few questions about your background
25 and experience. Can you please describe your educational

1 background?

2 A I have a four-year degree in nursing. I am a registered
3 nurse.

4 THE WITNESS: Do I have this situated right? Can you
5 hear me?

6 THE COURT: We hear you fine. Thank you.

7 A I have a master's degree in nursing. I have the clinical
8 nurse specialist board certification in psychiatric nursing
9 which is analogous to a nurse practitioner in the medical
10 field. And I also have a Ph.D. in law, policy, and society.

11 BY MS. VAN EREM:

12 Q Have you worked as a nurse?

13 A I have.

14 Q How long have you worked as a nurse?

15 A Approximately 47 years.

16 Q What is the role of a psychiatric clinical nurse
17 specialist?

18 A The role of a psychiatric clinical nurse specialist is also
19 called an advanced practice role, so a nurse who can function
20 in an expanded role, meaning he or she can diagnose, can treat,
21 can supervise other nurses, contributes, in a way, making
22 healthcare changes more on a global level.

23 Q Do you have experience working with people with mental
24 illness?

25 A I do.

1 Q How long have you been working with people with mental
2 illness?

3 A I would say for 47 years. It's my entire career.

4 Q For the individuals with mental illness that you have
5 worked with over the years, what is the range of severity of
6 their illnesses?

7 A I have worked with people who have temporary conditions,
8 conditions that are adjustment disorders, maybe a grief
9 reaction or an anxiety or a depression, and I have also worked
10 with people who have very serious and persistent mental
11 illness.

12 Q Has the majority of your work been spent with people with
13 serious and persistent mental illness?

14 A It has.

15 Q Have you worked in both hospital and community-based
16 settings?

17 A I have.

18 Q Can you just describe generally your experience working in
19 each of those settings?

20 A Early on in my career I worked in a community psychiatric
21 hospital. It was a small locked ward, primarily short-term
22 stays for people. And later on in my career, starting in about
23 the seventies, I worked more with people who were coming out of
24 a state hospital.

25 Q Can you tell us a little bit more about that role working

1 with people coming out of the state hospital?

2 A I was hired by the Department of Mental Health in
3 Massachusetts, and I was part of a small team. I was the nurse
4 on that team, and the team was tasked with bringing people out
5 of the state hospital, about 300 people, and integrating them
6 into the community. And thereby the team was also tasked with
7 developing community-based services to support those people.

8 THE COURT REPORTER: I'm sorry.

9 A Tasked with developing services that would support those
10 people in the community.

11 BY MS. VAN EREM:

12 Q What year did you begin working in that role?

13 A In 1978.

14 Q What were the circumstance in which those teams were
15 formed?

16 A At that time the Commonwealth of Massachusetts was in the
17 process of deinstitutionalization. They had statewide funding
18 to do this. The goal was to close many of the state hospitals
19 in the state and to integrate the majority of people in those
20 state hospitals into the community.

21 Q What was your role on that team?

22 A My role was -- the title was community nurse advisor,
23 aftercare services coordinator. What the role was to -- I
24 coordinated comprehensive clinical services in the community
25 for people coming out of the hospital and integrating into the

1 community. So it was to be part of this team to develop
2 services and also to see patients directly.

3 Q And did you work with the state hospital in that role?

4 A Yes. That was a big part of the role, was to interface
5 with the state hospital to meet with staff there on a regular
6 basis to talk about plans about how we would help people come
7 out. So it was a very big piece of the work.

8 Q And as part of this role, did you develop community-based
9 services?

10 A I did.

11 Q And we'll talk a little bit more later about some of the
12 community-based services that you worked on developing. But
13 after your role as community nurse advisor, did you have any
14 other roles in developing community-based services in
15 Massachusetts?

16 THE COURT REPORTER: I'm sorry.

17 BY MS. VAN EREM:

18 Q After your role as community nurse advisor, did you have
19 any other roles in developing community-based services in
20 Massachusetts?

21 A I did.

22 Q What were those roles?

23 A I was director of outpatient services for a period of time
24 and then I became director of outpatient services. As the
25 agency grew and more and more people became patients in the

1 community-based setting, the role expanded. And then
2 ultimately I was the vice president for quality management
3 within that agency.

4 Q What were your responsibilities as director of adult
5 services and outpatient services?

6 A That was to coordinate services that had been developed for
7 the people to make sure that they were operating at their most
8 effective level, to supervise staff, to meet with patients and
9 their families, and to also interface with the hospital staff
10 at various levels.

11 Q You testified that you developed and supervised
12 community-based services in Massachusetts. At a high level,
13 can you describe the community-based services that were
14 developed?

15 A Yes. It was the continuum of care within the community.
16 So to start with, 24-hour crisis. And we had developed that
17 from the beginning, so I was actually one of three prescreeners
18 on that team just to get a sense of how the operation was
19 going. So we had the 24-hour crisis.

20 We also had an outpatient medication clinic which was
21 dispensing, monitoring, prescribing. We developed housing
22 within the community, a variety of housing. We also had a case
23 management function where people would visit people in their
24 homes or people would come into the office for meetings and so
25 to stay really in touch with the folks that we had brought out.

1 We interfaced with various community agencies and had contracts
2 with those agencies to work with them, agencies that interface
3 with patients. And we had day programs and supported
4 employment.

5 Q What was the time frame in which these services were
6 developed?

7 A We started in 1978, and in 1980 we received a federal
8 community mental health center grant, so it grew then in leaps
9 and bounds. And I would say over the next five years that we
10 had developed those services.

11 Q When did you leave your work in the Massachusetts mental
12 health system?

13 A That was in 2009.

14 Q Where did you work after that work with the Massachusetts
15 mental health system?

16 A I worked at the Veterans Administration in Boston, the V.A.
17 Medical Center.

18 Q When did you work for the Veterans Administration?

19 A I started there in 2009 and I stayed until 2015.

20 Q What was your role?

21 A I was the nurse manager for the Home-Based Primary Care
22 Program.

23 Q What is the Home-Based Primary Care Program?

24 A Home-Based Primary Care Program is a -- it's a national
25 model that the V.A. has developed, and it is geared completely

1 towards serving veterans in their homes. And so it is a
2 multidisciplinary team with nurses and case managers and social
3 workers and doctors. And everything was completed in the
4 patient's home through patient visits. And the goal was to
5 keep people out of the hospital to avoid nursing home placement
6 or at least to have short hospital stays.

7 Q As part of your work experience, have you conducted
8 clinical assessments of individuals with mental illness?

9 A I have.

10 Q Why do you conduct assessments in your work?

11 A In nursing, but I believe in all healthcare professions,
12 the assessment is that it is the foundation of the work that
13 you are going to be doing with the patient so it's very
14 important to do that initial assessment with the individual for
15 a variety of reasons.

16 Q What sources of information did you use in completing those
17 assessments in your prior work history?

18 A Well, it's a fairly standard outline, but first you would
19 ask the person why they are coming, then what is it that's
20 troubling them or what their presenting problem is, but then
21 also to talk with them about their history, their mental
22 history or their medical history, their family history, their
23 social history, any kinds of contributing factors that might
24 play into what kind of treatment might be best for this person
25 and their problem, and to also ask them what they want, what

1 would work for them, their goals.

2 MS. VAN EREM: Your Honor, I move to have Dr. Judith
3 Baldwin qualified as an expert in psychiatric nursing, serious
4 mental illness, and assessments for community-based mental
5 health services.

6 THE COURT: Any objection?

7 MR. SHELSON: No, Your Honor.

8 THE COURT: Dr. Baldwin will be admitted as an expert
9 on the designated -- in the designated areas.

10 You may proceed.

11 MS. VAN EREM: Thank you, Your Honor.

12 BY MS. VAN EREM:

13 Q Dr. Baldwin, I would like to talk now about the review you
14 conducted in Mississippi. How many individuals were in your
15 review?

16 A Thirty.

17 Q What sources of information did you use in making your
18 determinations in your review?

19 A What sources of information did I use?

20 Q Yes.

21 A I interviewed the individual. Whenever available, I also
22 interviewed collateral contacts, which could include family
23 members or friends or other people that would have some
24 informal relationship with them. I reviewed medical records
25 from the State Hospital and from the CMHCs.

1 Q Where did you conduct the interviews?

2 A That was in a variety of places. We met with people in
3 their own homes, we met with people in their family's homes,
4 personal care homes, group homes, nursing homes. I also went
5 to two state hospitals, two correctional facilities, and I also
6 met with one individual at the college in -- on Capitol Street
7 in Jackson, Jackson State College.

8 Q What records did you review?

9 A I reviewed all records that were provided to me. That was
10 State Hospital records, community mental health center records.
11 And within those, sometimes there were discharge summaries or
12 other summaries from the community hospitals as well.

13 Q Did you submit a final report?

14 A I did.

15 Q If you will turn in your binder to tab 403. Is PX-403 your
16 report?

17 A It is.

18 Q After your report was finalized, did you have an addendum?

19 A I did.

20 Q What did your addendum consist of?

21 A I had the occasion -- we had tried to interview family
22 members and other collaterals, as I said, when they were
23 available. And a response came back to my outreach on that
24 after I had submitted my final report, and it was the brother
25 of one of the folks in my sample. And so I did interview him,

1 but my report had gone in. So what I did was document that
2 interview and I submitted it as an addendum.

3 Q Is your addendum in front of you labeled PX-399?

4 A Yes, it is.

5 Q Dr. Baldwin, did you also submit an errata to your report?

6 A I did.

7 Q Are the corrections you made in your errata contained in
8 the document called Errata to Expert Report of Dr. Judith
9 Baldwin dated May 24th, 2019 and labeled PX-403A?

10 A It is.

11 Q How would you describe those corrections?

12 A The first bullet is there was a mistake in calculation. I
13 had answered the question about is an individual at serious
14 risk for institution in a State Hospital, and I said 19 and it
15 should have been 18. I had miscounted or miswritten it in the
16 report. I actually rendered an opinion on three of those
17 people.

18 The other errata is I had a typo that I found upon later
19 review where I had put the date as '17, 2017, when, in fact, it
20 was 2015.

21 MS. VAN EREM: Your Honor, PX-403, Dr. Baldwin's
22 report, has been preadmitted but I move to admit PX-399 and
23 403A into evidence.

24 THE COURT: PX --

25 MS. VAN EREM: 399 and 403A, which are her addendum

1 and errata.

2 THE COURT: Any objection from the State?

3 MR. SHELSON: No, Your Honor.

4 THE COURT: All right. PX-399 and 403A will be
5 received into evidence.

6 (EXHIBITS PX-399 AND PX-403A MARKED)

7 BY MS. VAN EREM:

8 Q Dr. Baldwin, does your report with the addendum and errata
9 you identified accurately reflect your opinions and conclusions
10 in this case?

11 A It does.

12 Q What standards did you rely on in reaching your
13 conclusions?

14 A I relied on my professional experience, also my -- of what
15 I have seen work over my career, what has been successful for
16 people similar to the people in the sample. I also relied on
17 my knowledge of evidence-based practices and what has been
18 proven to work for individuals living in the community with
19 serious mental illness.

20 I also relied on reviews of the literature both that I had
21 access to and was familiar with, but also that was provided to
22 me by Dr. Robert Drake who was the lead on the team, outlining
23 again evidence-based practices for success in the community.

24 Q Let's briefly go over what you were determining in your
25 conclusions and then we will go back and talk about your

1 conclusions more. First, what were you trying to determine for
2 the 30 individuals you reviewed?

3 A I was trying to determine if, one, if they would oppose
4 receiving community-based services or living in the community
5 if community-based services were -- or reasonable services were
6 available to them. I was trying to determine if they had spent
7 too much time in a state hospital or could have avoided some of
8 the admissions or all of the admissions that they had
9 experienced.

10 I was also looking at would they be appropriate for
11 community-based services and would they benefit from them. And
12 finally, if they were at risk for rehospitalization.

13 Q Do you have a demonstrative slide showing your findings
14 regarding these questions?

15 A I believe I do.

16 MS. VAN EREM: Your Honor, may I approach?

17 THE COURT: Yes, you may.

18 BY MS. VAN EREM:

19 Q (Tenders document.) This has been marked for
20 identification as PDX-18. Does this slide fairly and
21 accurately depict your findings?

22 A It does.

23 Q Starting with the first finding on this slide, for the 30
24 people you reviewed, how many did you find could have avoided
25 or spent less time in the State Hospital with reasonable

1 community-based services?

2 A I found that all of them could have avoided or spent less
3 time in the hospital.

4 Q How did you go about answering the question of whether the
5 person would have avoided or spent less time in the State
6 Hospital?

7 A It was a combination of things. I looked at the record,
8 the records that were provided to me and what the circumstances
9 were around the admissions. Also, I looked at the pattern of
10 admissions, if the same kinds of things were happening each
11 time in between. I looked at the community-based services that
12 were or were not being provided either before and/or in between
13 hospital admissions.

14 I also spoke with the individuals and oftentimes with
15 family members or others who were familiar with their
16 experience and asked did they think they could have avoided
17 going in the hospital had something been available to them and,
18 if something was available, what was it, and asked them to
19 identify it. And often, they did.

20 Q Generally, why did you find that all 30 individuals in your
21 review could have avoided or spent less time in a State
22 Hospital?

23 A These individuals are very similar to people that I have
24 worked with in my career, and I am aware of what works for
25 people living with serious mental illness, as these individuals

1 are, and am aware that if they had had access to those
2 services, then they could have avoided or at least have had a
3 much shorter stay in an acute care setting.

4 Q Going to the second question, how many individuals did you
5 find were at serious risk of institutionalization?

6 A And I found that it was 18, and that is 86 percent of the
7 people that were out of the hospital at that time.

8 Q And so that's out of the 21 people who were in the
9 community at the time for whom you formed an opinion. Is that
10 right?

11 A Correct.

12 Q How did you reach the conclusion that these individuals
13 were at serious risk?

14 A I was looking at the patterns of their hospitalizations and
15 looking at the -- what community services were or were not
16 available to them, and noticing that the same situation was
17 happening over and over again, and that there was limited
18 community-based services that were either in place when they
19 left the hospital the last time or if they had not been in the
20 hospital, they weren't in place so that really the individuals
21 were at risk because nothing -- there wasn't much that was
22 supporting them in the community in between.

23 Q What can happen when a person with serious mental illness
24 is not getting the services they need to support them?

25 A Serious mental illness is a chronic disease. People can

1 live successfully in the community. They can recover, but they
2 also will have exacerbations of symptoms on occasion. And in
3 particular, if they are not receiving supports or they're not
4 taking medication or they're not working with a service to help
5 them stay stable in the community, and their symptoms will
6 increase periodically and they -- if they are left untreated,
7 they will exacerbate to the point where they may need a higher
8 level of care.

9 Q Can you provide an example of someone who you determined
10 was at serious risk of hospitalization at the time you reviewed
11 them? And you can reference PX-400 in your binder, which is a
12 list of names of individuals involved in the review, along with
13 their numbers, which we will be using the numbers to preserve
14 confidentiality.

15 A And so to be clear, you would ask me about someone who is
16 at serious risk?

17 Q That's right.

18 A Okay. I would like to talk about person 107.

19 Q Can you please briefly describe the circumstances of person
20 107? And it starts on page 136 of your report.

21 A Person 107 is a 69-year-old woman. She lives in a
22 retirement community. She has worked her whole life. She,
23 when well, lives very independently. She is a college-educated
24 woman, has had a very successful career. She has two
25 daughters. And she is diagnosed with bipolar illness.

1 Q How many times has person 107 been in a State Hospital?

2 A She has been in the State Hospital four times.

3 Q What led to those State Hospital admissions?

4 A This is -- her situation is fairly typical of someone who
5 is diagnosed with bipolar illness. In the case of person 107,
6 she might become feeling very well and decide that she doesn't
7 want to take a dose of her medication or she might feel
8 suspicious about her medication and over time gradually take
9 less and less of her prescribed medication. And then, as her
10 daughter described, and as described in the record, she
11 escalates into a full manic state, which is characteristic of
12 bipolar.

13 Q What do you mean when you say manic state?

14 A When people have bipolar I, which is what person 107 has,
15 it's characterized by extreme mood swings, both mania where
16 people are not sleeping, they have extreme euphoria, they are
17 oftentimes agitated, they may have some strong suspicions but,
18 in a sense, the world is all great and they don't need any
19 medication, they don't need any help, they are not sleeping,
20 they are not using good judgment.

21 It also has the reverse where people can be very, very
22 seriously depressed.

23 Q Why did you ultimately conclude that person 107 was at
24 serious risk of further State Hospital admissions?

25 A In speaking with her daughter, as well as herself, the

1 daughter, both she and her sister believed this is the only
2 path to get -- commitment is the only path to get their mother
3 stabilized and back on her medication, that they acknowledge
4 that they cannot do this by themselves, that they try and she
5 will not listen to them because she thinks everything is fine.

6 Q Are there community-based services that could reduce person
7 107's risk of State Hospital admission?

8 A Do you mean do they exist?

9 Q Yes. Generally, would there be community-based services
10 that could reduce her risk?

11 A Absolutely.

12 Q What types of services would reduce her risk?

13 A In the case of person 107, the important thing for her is,
14 one, to have a 24-hour crisis line and, if not for her, for her
15 daughters who might become concerned about her and could talk
16 with a crisis clinician early on. Also to have, in her case, a
17 case manager who has a trusting relationship with her, sees her
18 on a regular basis on outreach and proactively and so can head
19 off these symptoms early on before they become so exacerbated
20 that she needs a higher level of care for her own safety.

21 Q Did person 107 have access to these services?

22 A No, I don't believe so. Could I add?

23 Q Sure.

24 A The other aspect is medication. Obviously, this is an
25 illness that is effectively managed by medication, so that

1 would be the other service that I would see as important for
2 her.

3 Q What is it about person 107's illness that makes you
4 confident that the services you mentioned could reduce her risk
5 of hospitalization?

6 A Because bipolar illness is one serious mental illness that
7 has been proven time and time again to be very effectively
8 managed by medication. It's also very predictable in that
9 people will have these cycles as I have described them. So --
10 and I have seen it work time and time again with very high
11 functioning bipolar people who respond very well to their
12 medication.

13 Q Let's go back to your overall findings. How many
14 individuals in your review did you find opposed receiving
15 services in the community?

16 A There were none who opposed.

17 Q How did you determine whether an individual opposed
18 community-based services?

19 A I looked at multiple sources of information. Whenever
20 possible, I would ask the individual themselves. Or in the
21 course of the interview, the individual would tell me, without
22 being asked, that they wanted to live in the community, they
23 knew what they would need in the community to stay there and to
24 live at their highest level of independence. I spoke with
25 family members, again, what they thought the person would need,

1 and they had a very good idea of what that would be.

2 And then I looked in the records and documentation of
3 people asking to leave the hospital or even identifying where
4 they wanted to live or what services they would need.

5 Q Can you briefly give an example of an individual who told
6 you that they preferred to live in the community?

7 A An example of someone who would prefer to live in the
8 community? Is that what you said?

9 Q Yeah, just a brief example.

10 A Yes. And do you want the number?

11 Q Sure. You can give me the number if you would like.

12 A I'm looking at one, person 91. And throughout his
13 interview talking about how he wanted to leave the nursing home
14 where he was and what he would need in the community to live
15 there. And it was so important to him and it was also
16 documented continuously in his medical records.

17 Q Go ahead.

18 A I was going to give another example as well.

19 Q Sure.

20 A And let me see her -- this is person 109. And this is a
21 young lady that I interviewed in the State Hospital who I found
22 out after the fact has been discharged to a small group home.
23 But she was very engaging, very animated, and talked about how
24 she just wanted to make it in the community. And in going back
25 into the hospital, she blamed herself every time. And, "I'm

1 not going to screw up this time. I'm going to get out there.
2 I want to go in a group home and then I want to get my own
3 place." And, you know, it was just very important to her.

4 Q Regarding the final question, how many individuals did you
5 find were appropriate for community-based services?

6 A I found that all the individuals in my sample were
7 appropriate.

8 Q Was that surprising to you?

9 A No.

10 Q Why not?

11 A Because I have seen it throughout my career that people can
12 live successfully in the community at a very high level of
13 independence who are also living with serious mental illness.
14 The community-based services are evidence-based. I have seen
15 them work time and time again. A different maybe combination
16 for an individual from one to another, but they do consistently
17 work.

18 Q Of the individuals you reviewed, how many were in the State
19 Hospital at the time you reviewed them?

20 A I believe it was eight.

21 Q Of those eight, can you explain generally why you
22 determined they were appropriate for community-based services?

23 A Because these are people not unlike the other people,
24 individuals in my sample who have a variety of serious mental
25 illness. They -- in each case, I identified strengths that

1 they had, which was different from one person to another, some
2 the same. But I have seen in the past that individuals like
3 this with similar symptoms, similar strengths and similar
4 challenges, can live successfully in the community.

5 Q Did you also determine the types of services that
6 individuals needed to remain in the community?

7 A I did.

8 Q How did you make that determination?

9 A There are a series of -- there is a continuum of care of
10 community-based services for people with serious mental
11 illness. They are evidence-based. And if you would like, I
12 can list them, but there is --

13 Q Sure. If you can briefly list them?

14 A To start with, the crisis services, 24-hour crisis, and
15 there is a continuum within the crisis which I won't go into,
16 but to start with, the 24-hour hot line and to have obviously a
17 mobile outreach capacity but also to have a crisis
18 stabilization on the other side of crisis. To have proactive
19 outreach through case management function. To also have access
20 to a psychiatric prescriber. To have, when it's needed, a
21 connection being made to primary care because often people with
22 serious mental illness have co-morbid medical conditions. To
23 also have supported housing, stable housing, and supported
24 employment as needed. And finally, for people to have
25 connection to specialty services that they might need such as

1 connection to trauma, because there are more people with
2 serious mental illness who have had trauma histories as well.

3 Q You mentioned case management. Can that be part of PACT
4 services?

5 A Yes. And PACT is also an evidence-based practice with
6 those services all within one team. And case management is a
7 very big part of that.

8 Q Can case management also be provided separately from a PACT
9 team?

10 A It can.

11 Q Are there any recommendations for services that you made --
12 sorry. Let me rephrase that.

13 Are there any examples of individuals where you have made
14 recommendations beyond those core services necessary to avoid
15 hospitalization that you just mentioned?

16 A I did.

17 Q Is person 110 an example?

18 A Person 110 is who I was thinking of.

19 Q Okay. And for person 110, did you say that he could
20 benefit from a program geared to supporting individuals with
21 dementia which included sensory stimuli such as recliners and
22 hand and neck massages?

23 A I did. And person 110 is one of the three people that I
24 said was not at risk for hospitalization. This is a -- a
25 relatively young man who is in the end stages or advanced

1 stages of dementia. When I interviewed him, he was on a
2 dementia unit in a nursing home. And what I did at that time
3 was make the recommendations that I know are clinically
4 appropriate for someone with that diagnosis.

5 Q So are those services geared -- you know, the program
6 geared toward supporting individuals with dementia, are those
7 services necessary to prevent his hospitalization in a State
8 Hospital?

9 A Not necessarily, no.

10 Q Why did you make the recommendation?

11 A It was my experience, my most recent experience in the
12 V.A., because our average age of our consumer was 85, and
13 oftentimes there was a diagnosis of dementia, and those are
14 evidence-based practices for people with dementia. So the
15 nurse in me, the clinician, made the recommendations I thought
16 were right for that man.

17 Q And I apologize if you already mentioned this, but is
18 person 110 at risk of admission to a State Hospital according
19 to your review?

20 A No, he is not.

21 Q Now that we have talked about your overarching findings, I
22 would like to ask about some more details. Did you make any
23 findings in your review regarding how often some individuals
24 are admitted to the State Hospitals?

25 A I did. Individuals -- I have at least one gentleman I can

1 think of who just went into the State Hospital one time, and
2 then I also have individuals on my -- in my sample who were
3 admitted 17 times.

4 Q Why would it occur that people would have many readmissions
5 to the State Hospital?

6 A Just so I understand, why would it occur if they would have
7 -- why would they have many?

8 Q Let me rephrase. Why did you find that people in your
9 review had many readmissions to the State Hospital?

10 A Often it was a dearth of community-based services in
11 between those admissions or even before the first that was not
12 supporting that individual in the community adequately, and so
13 their symptoms would exacerbate, as I described before, and
14 then they would perhaps require a higher level of care for
15 safety.

16 Q You mentioned that some people had fewer State Hospital
17 admissions than others?

18 A I did.

19 Q Why did some people have fewer admissions?

20 A Well, the one gentleman that I'm thinking of who had the
21 one admission, he is a young man. He was in his thirties, and
22 I believe that he would be at risk for rehospitalization. It
23 would just be a matter of time. But he was young.

24 There is also the factor of supports. If people have a
25 number of supports in the community and formal supports, then

1 that often can delay or prevent hospitalization because those
2 supports are taking care of the individuals.

3 Q Dr. Baldwin, did you get a sense for what people's
4 experiences were in state hospitals?

5 A I did. People would often tell me unsolicited, but I would
6 also ask that. I would ask, you know, what was good about
7 being in the state hospital, what did you not like in the state
8 hospital, what recommendations would you make. And they would
9 answer in that way as well.

10 Q And what did you learn from asking those questions?

11 A I learned that there were a number of people. There was
12 one woman who told me it was the most humiliating experience
13 she had ever had in her life. There was at least a couple of
14 people who said it was like a prison, that they had been picked
15 up by the police and that they had been taken against their
16 will.

17 Often people talked about not having choice. More than one
18 person described lining up to get medication. People talked
19 about not having privacy, not having access to their things.
20 One lady said, "I like to brush my teeth more than once a day
21 and when I go back, my toothbrush is gone, it is put away."

22 Q Can those experiences that you just described occur even
23 with short admissions?

24 A They can, yes.

25 Q Can you provide an example from your review of someone who

1 has been admitted multiple times to State Hospitals?

2 A I can. Let me find the number for you.

3 Q Sure.

4 A This is person 98.

5 Q And can you describe person 98? It's page 89 of your
6 report.

7 A Person 98 is a 53-year-old man. You said 89. Right?

8 Q Page 89, yes, 88 or 89.

9 A Got it. It's a 53-year-old man. He currently lives in a
10 personal care home. He is college-educated. He has had an
11 employment history in the past. He is diagnosed with
12 schizoaffective disorder, bipolar type. And I saw him -- I
13 interviewed him at the community mental health center.

14 Q How many times has person 98 been in the State Hospital?

15 A He has been in the State Hospital 14 times, according to
16 the records.

17 Q What were the reasons that person 98 had been admitted to
18 the State Hospital 14 times?

19 A Now, his appears to be a cyclical process as well. These
20 admissions, he said the 14 admissions which have taken place
21 over the past 28 years, so starting when he was a young man,
22 and about every two years. But what happens with him is his
23 symptoms start to increase very insidiously, and it may be
24 because he may skip a dose of medication or he may decide he is
25 not going to take his medication. And then he gradually

1 escalates into a threatening stance. He gets agitated. He
2 gets angry. And the personal care home manager becomes
3 concerned, and the other residents become fearful. And so a
4 commitment process is initiated with him, which is what
5 happened this last time.

6 Q In your opinion, could some of person 98's hospital
7 admissions have been avoided or shortened?

8 A Absolutely.

9 Q How did you make that determination?

10 A Because he has a cyclical nature to his decompensations,
11 meaning that his symptoms increase in kind of a predictable
12 way. And so to have a case manager who is engaged with him
13 right from the start in a trusting relationship to kind of head
14 off symptoms or get a sense of them right from the beginning to
15 then thereby avoid them escalating into an acute situation.
16 Also to have 24-hour crisis service, and that would be not only
17 available to the individual but also to the personal care
18 manager to call ahead and say, "I think, you know, person 98,
19 just I'm a little concerned, he is not sleeping, he is, you
20 know, he is getting a little angry or losing his patience."

21 Q Did person 98 have access to those community-based services
22 before his State Hospital admissions?

23 A Not that I'm aware of, no.

24 Q Did you recommend that person 98 would be appropriate for a
25 PACT team?

1 A I did.

2 Q What is it about PACT services that gives you confidence
3 that person 98 could avoid repeated hospitalizations?

4 A PACT has a team approach and within that team is the access
5 to the 24-hour crisis services and mobile outreach within that.
6 Also, a crisis stabilization, which I think would be very
7 appropriate for him. Also, the case management function. And
8 again, the proactive outreach case management function.

9 He is someone who takes medication. He is not opposed to
10 it. So that piece, connection to the medication through the
11 PACT team as well.

12 And he is an individual who would like to be doing
13 something during the day, either a day program or some kind of
14 work. And the PACT team could support him in that regard, in
15 addition to possibly stepping down from a personal care home
16 into a more independent level. The PACT team could help him
17 with that as well.

18 Q Is person 98 at serious risk of hospitalization in a State
19 Hospital?

20 A Yes, he is.

21 MS. VAN EREM: Your Honor, it is my understanding
22 there has not been a morning break. If you would like, we can
23 take a break now. It's a natural stopping place. Or I can
24 keep going.

25 THE COURT: Oh, it is a natural stopping place?

1 MS. VAN EREM: Yes.

2 THE COURT: All right. For you?

3 MS. VAN EREM: Yes.

4 THE COURT: Okay. All right. We will take our
5 15-minute break then.

6 MS. VAN EREM: Thank you, Your Honor.

7 THE COURT: Doctor, you may step down.

8 THE WITNESS: I can sit right here?

9 THE COURT: If you wish -- if you want to stay there?

10 THE WITNESS: No. I think I would like to use the
11 restroom.

12 THE COURT: Okay. Yeah. You can step down. By all
13 means.

14 We are in recess. We are in recess.

15 (RECESS)

16 THE COURT: Is there anything we need to take up?

17 MS. VAN EREM: Not from the United States.

18 THE COURT: All right. Are you ready?

19 THE WITNESS: I am.

20 THE COURT: All right. You may proceed.

21 MS. VAN EREM: Thank you, Your Honor.

22 BY MS. VAN EREM:

23 Q Dr. Baldwin, I would like to continue talking about your
24 findings, specifically that people could have avoided or spent
25 less time in State Hospitals. Did you find that a lack of

1 access to community-based services led to unnecessary
2 hospitalizations?

3 A I did.

4 Q And did you find that a lack of access to community-based
5 services led to hospitalizations that were longer than
6 necessary?

7 A I did.

8 Q What was the length of stay in State Hospitals for the
9 individuals that you reviewed?

10 A There was a range. Some individuals stayed as short a time
11 as a week. I have one individual within my sample who had a
12 singular hospitalization that was 17 years, another woman 13 or
13 14 years.

14 Q You say 17 years?

15 A Yes. Years.

16 Q Are there any examples you can think of of the individuals
17 you reviewed who could have avoided or spent less time in State
18 Hospitals?

19 A I can give a couple of examples if you want. The first one
20 is person 90.

21 Q Can you please tell us a little bit more about person 90?
22 It's on page 21 of your report.

23 A Person 90 is a 64-year-old African-American woman. She is
24 the mother of two daughters. And when I interviewed her, she
25 was in a personal care home. She is diagnosed with

1 schizophrenia. She does have some co-morbid medical
2 conditions. Prior to her most recent hospitalization, she had
3 been out of the hospital for five years and had been living in
4 her own apartment.

5 Q What led to her most recent hospitalization?

6 A Person 90 takes psychotropic medication. She apparently
7 had missed a medication appointment. And then she had missed
8 several medication appointments over a five-month period. And
9 during that time -- a four- to five-month period. And during
10 that time, she also was not paying her rent. She somehow
11 thought she was paying her rent but she was not.

12 Q Who initiated her commitment?

13 A That was her daughter.

14 Q I apologize if I missed this, but you had said she had
15 missed some medication appointments. Is that right?

16 A She had. She had missed approximately five months worth of
17 medication appointments, which was about five appointments.

18 Q What actions were taken when person 90 started missing
19 appointments?

20 A I could find very little actions in the record. There was
21 one notation of an outreach, but I don't believe the case
22 manager reached person 90. And then I could not find any other
23 follow-up.

24 Q Based on your experience, what should have happened when
25 person 90 started missing appointments?

1 A This is an individual where I believe a case manager or
2 proactive case management function should be very much involved
3 with. And she was someone who came to her appointments. And
4 so for her to miss an appointment would have warranted a
5 follow-up. In the case of person 90, ideally, the case manager
6 should be seeing her regularly on a very regular proactive
7 basis. But in missing an appointment, the case manager would
8 follow up, make a call. If she did not -- he or she did not
9 reach person 90, to go make a home visit, figure out what's
10 going on, talk with the daughter, talk with the landlord and
11 try to, again, head off symptoms before they exacerbate into
12 a -- in this case, it was five months.

13 Q Had person 90's services been more intensive, could they
14 have prevented her State Hospital admission?

15 A I believe so, yes.

16 Q Regarding her hospital admission, based on your review, why
17 did person 90's daughter initiate commitment?

18 A What was in the record is that person 90 had not been
19 paying her rent and she had been evicted. She was subject to
20 being evicted and ultimately was. And the daughter, even
21 though it's throughout the record the daughter supports her
22 mother living independently, she manages her own finances and
23 does very well on her own, and the daughter supports that. But
24 in this case the daughter was -- knew that her mother's
25 symptoms were exacerbating and was fearful that she would be

1 homeless.

2 Q Based on your review, was the daughter aware of other
3 alternatives?

4 A No.

5 Q Did person 90 go immediately to the State Hospital after
6 her daughter initiated commitment?

7 A She did not.

8 Q Where did she go?

9 A She went to a community hospital.

10 Q How long was she in the community hospital?

11 A I believe approximately three weeks.

12 Q If you will turn to tab 1108 in your binder, the document
13 marked PX-1108.

14 A Yes.

15 Q Do you recognize this document?

16 A I do.

17 Q What is it?

18 A It is a psychiatric evaluation, and it's with the address
19 at the top, Merit Health Batesville, and it pertains to
20 person 90 admission there on 9-19-2016.

21 Q And was this written at the time of discharge of person 90
22 from the community hospital?

23 A Yes.

24 Q Did you rely on this record in reaching findings about
25 person 90?

1 A I took it into consideration among the other records that
2 were provided for me.

3 MS. VAN EREM: Your Honor, I move PX-1108 into
4 evidence.

5 THE COURT: Any objection from the State?

6 MR. SHELSON: No, Your Honor.

7 THE COURT: PX-1108 will be received in evidence.

8 (EXHIBIT PX-1108 MARKED)

9 BY MS. VAN EREM:

10 Q I will direct you to the paragraph on page 3 where it says
11 "Discharge Criteria." What does that say?

12 A It says, "Discharge Criteria: No SI, no HI," which is
13 suicidal ideation, homicidal ideation. "No psychosis. No
14 mania, depression, anxiety, irritability, anger, less than 3
15 out of 10, --

16 THE COURT REPORTER: I'm sorry.

17 THE WITNESS: I'm sorry.

18 A "No mania, no depression, anxiety, irritability, anger,
19 less than 3 out of 10, if 10 is the worst." Period. "No side
20 effects to medication and fully alert and oriented. However,
21 this is" or "will likely not apply to her as I strongly believe
22 she will be committed to the State Hospital and leave here to
23 go on to the State Hospital."

24 BY MS. VAN EREM:

25 Q What did you conclude after reading this record?

1 A What I concluded is the physician who was her attending in
2 the hospital had taken care of her for three weeks. She was
3 very stable. This physician writes that there was no evidence
4 of symptomatology of serious mental illness present, no
5 lethality, no danger to herself or others, she was oriented,
6 and that this physician had stabilized her. But this last
7 sentence implies that it doesn't matter, she is going to the
8 State Hospital anyway.

9 Q Generally, if someone is stabilized, do they need treatment
10 in the State Hospital?

11 A No.

12 Q Why not?

13 A Because they have stabilized, they are no longer in need of
14 acute care, meaning for acute care you would need to be unable
15 to care for yourself or a danger to yourself or others, and
16 this is not apparent in this paragraph at all.

17 Q In addition to concluding that person 90's most recent
18 State Hospital admission could have been avoided, did you make
19 any determinations regarding her length of stay in the State
20 Hospital?

21 A I did.

22 Q What was that determination?

23 A It appeared that she stayed too long.

24 Q How long was her most recent stay?

25 A I want to go back to her report.

1 Q Sure. It should be around page 22.

2 A Her most recent stay, I believe, was approximately 13 weeks
3 in total. She came in in October, and she didn't leave until
4 January. October of 2016 and then January 2017.

5 Q What was your conclusion that person 90 stayed too long in
6 the State Hospital based on?

7 A Well, the indication of the community hospital said she
8 went and she was stable and did not have any exacerbation of
9 symptoms then. There was also a report in the record two days
10 later from Mississippi State Hospital that determined that she
11 did not meet criteria for admission on 10-13.

12 Also in the record, it indicated as early as the end of
13 November that she appeared to stabilize and was at that time
14 offered the option of a group home. But she didn't go until
15 the third week in January 2017. So it seemed like a long time,
16 to me, to stay in the State Hospital.

17 Q In your opinion, could she have been discharged sooner?

18 A Yes.

19 Q Once she was admitted to the State Hospital, what should
20 have been taking place while she was there?

21 A At the very first, to begin the discharge planning on the
22 day of admission. And the concern for this woman is that she
23 was living in her own apartment and she had become evicted from
24 that apartment. So a similar situation would need to be
25 procured for her so that she could go back to that level of

1 independence in the community. So to start working on that
2 right away in conjunction with person 90 and person 90's
3 daughter.

4 Q Did any of that occur?

5 A It wasn't apparent, not to my knowledge. There was no
6 indication that an apartment was being looked for for person
7 90. She was offered a personal care home.

8 Q How had person 90's circumstances changed from the time
9 that she stopped going to medication appointments to the time
10 that she was discharged from the State Hospital?

11 A Her circumstances changed in that she had been living in
12 her own apartment, she had been living at a high level of
13 independence, she was managing her own finances, she was out
14 and about in her community, and then she was committed and
15 stayed in the hospital for the 13 weeks and then was discharged
16 to a much more dependent setting, a personal care home. So she
17 took a step down in her independence.

18 Q Can you describe another example of a person who would have
19 avoided or spent less time in a State Hospital?

20 A I can talk about person 104.

21 Q Okay. What are the circumstances of person 104 on page 125
22 of your report?

23 A Person 104 is a young woman. She is 38 years old. She is
24 diagnosed with schizophrenia. She has had a trauma history, a
25 lot of mental illness in her own family. She is working now

1 towards getting her GED. She is an artist. When I met with
2 her, she showed me her pieces which are very, very interesting,
3 very modern looking. And she has, I believe, been in the
4 hospital four times.

5 Q Did you interview another individual involved in person
6 104's life?

7 A I did. And that is the -- her informal caregiver who is
8 the wife of the pastor of person 104's church, who has been, by
9 person 104's report, tremendously supportive to her. She calls
10 her her -- I think it's her godmother or her fairy godmother,
11 that she just sees her as such an angel.

12 Q Focusing on person 104's last admission, what led you to
13 find that person 104 could have avoided or spent less time in
14 the State Hospital?

15 A She had also -- this was an individual who had an
16 apartment. Her symptoms were starting to exacerbate which in
17 her case is characterized by fighting, agitation. She was
18 destroying property and was not able to be in that apartment
19 any longer. And so she was, in fact, committed to the State
20 Hospital.

21 Q Did person 104 stabilize quickly when she was committed to
22 the State Hospital?

23 A She did. She did. She stabilized very quickly, according
24 to the records.

25 Q What happened after she stabilized?

1 A She stayed there. She actually stabilized I believe within
2 a week from her admission. She was admitted on May 31st, 2017,
3 and appeared to stabilize by June 6th. The problem was trying
4 to find housing for her, that that was what was indicated in
5 the record because she couldn't go back to her apartment, she
6 had destroyed it, according to the record, and that she had
7 very difficult relationships with family so she couldn't go
8 back with them.

9 Q After she had stabilized, did she have any incidents in the
10 State Hospital?

11 A She did. She had -- there was an incident of -- she had
12 talked with me and it was also in the record about noise really
13 bothers her to the extreme, which I'm associating with some
14 kind of traumatic event in her past. She does have a trauma
15 history. But the noise really bothers her.

16 She had a couple of events of one where she threw a binder
17 and another where she had destroyed some fixtures in a
18 bathroom.

19 Q And do you believe person 104 could have been discharged
20 sooner than she was?

21 A Absolutely. I think the window was missed; that she had
22 stabilized quickly, she was not discharged, and then the
23 environment of the State Hospital and the noise triggered her,
24 for whatever reason, and she had some problems.

25 Q You mentioned some past aggressive behavior of person 104.

1 Is that right?

2 A Yes.

3 Q In your experience, can individuals with a history of
4 aggressive behavior be safely served in the community?

5 A Absolutely. And once stabilized and services are provided
6 to them, be it by a PACT team, case manager, connection with
7 CMHC, then yes, they can live at a very high level of
8 independence. And this woman has evidence. She told me on the
9 interview that she now is living in a five-room house and
10 living independently there. The house was obtained for her by
11 her church.

12 Q Did you make a determination that person 104 is at serious
13 risk of hospitalization?

14 A Yes.

15 Q You determined that she was?

16 A Yes, I did.

17 Q What services could help person 104 live safely in the
18 community?

19 A She is an individual who is appropriate for a PACT team.
20 The services that are within that PACT team I believe are very
21 appropriate for her, specifically case management, which would
22 offer, augment what the church is doing for her now, to give
23 support to her informal support network so they are not the
24 only ones. Also, the 24-hour crisis so that before symptoms
25 exacerbate, to be able to contact, have local outreach --

1 THE COURT REPORTER: I'm sorry.

2 A To have access to 24-hour crisis service, to have mobile
3 outreach so that she could have contact before her symptoms
4 would exacerbate and would require her to be in a hospital.
5 Also, support around her medication, her psychotropic
6 medication connection there, support around her goals, which
7 she has goals. She wants to get her high school diploma. She
8 wants to pursue her art.

9 BY MS. VAN EREM:

10 Q Had person 104 received these services?

11 A No.

12 Q Had she received any community-based services?

13 A She -- I also, as part of the collateral, interviewed the
14 community mental health center staff who were working with her.
15 In the record it shows that she comes in for a medication
16 appointment, though in my opinion the appointments are too far
17 apart. She also sees a nurse. And then there is a case
18 manager that visits her. But when I spoke with the case
19 manager, she really wasn't too familiar with -- because I
20 thought the five-room house was so wonderful, but the case
21 manager really wasn't too aware of that.

22 And the visits by the case manager did not seem to be in
23 keeping with any kind of exacerbation of symptoms. There
24 wasn't any indication that she stepped up the visits or did
25 anything more during that period of time when person 104 was

1 starting to have problems in the community.

2 Q Could more intensive services have prevented person 104's
3 hospitalization?

4 A I believe so, yes.

5 Q Dr. Baldwin, you testified earlier that the lack of
6 community-based services has led to individuals being admitted
7 unnecessarily or staying longer than necessary in State
8 Hospitals. I would like to draw your attention to crisis
9 services specifically. What is the goal of crisis services?

10 A The goal of crisis service is three-fold. It is to divert
11 from hospital whenever possible, to stabilize the individual,
12 and to then connect them to the next level of care, the most
13 appropriate level of care for them.

14 Q You mentioned earlier that you developed crisis services in
15 your work in Massachusetts. Is that right?

16 A I did.

17 Q Can you just briefly describe the crisis services that you
18 developed?

19 A Yes. It's a continuum. It should begin with a proactive
20 advanced crisis plan which is developed in conjunction with the
21 individual, any supportive family members or friends, to talk
22 with that individual when they're stable about what they would
23 like to have happen to them if they start to get into a problem
24 area with their medications. So first that.

25 But then at the lowest level, a "warm" line where someone

1 can call and chat for a variety of reasons, then a hot line
2 where a person would call to get connected to a crisis service
3 or be triaged for crisis, and then to have the mobile outreach
4 capacity where clinicians are actually available to go out to
5 where that individual is, be it their home or some other place.
6 It could even be under a bridge or in a group home or whatever.
7 Also, the capacity for people to come into an office to be able
8 to meet with someone there if that would be preferable for them
9 to do that.

10 And then to also have a crisis stabilization unit which is
11 a short-term diversionary unit which can see people, have them
12 be stable, talk with people, get reconnected with their
13 medication, get connected with an appointment, whatever they
14 need, and then to be discharged back home from the CSU.

15 Q When were the crisis services that you testified about
16 developed in Massachusetts?

17 A They were.

18 Q When were they developed?

19 A Oh, when? We started right at the beginning in 1978 with
20 the prescreening and then added services as we went along.
21 Obviously, the prescreening emergency services center was open
22 right then so people could come in, but we also had go-out
23 capacity.

24 And then we -- the warm line and the hot line also right
25 then in 1978. And then DCSU was later after we had established

1 the first part.

2 Q And I'm not sure you mentioned the term "prescreening"
3 before. Can you describe what prescreening is?

4 A Prescreening, that's what we called it. I don't know -- I
5 mean, it can go by a lot of different names but it is a mobile
6 outreach capacity where a family member, anyone who is involved
7 with a patient -- it could be law enforcement, it could be a
8 homeless shelter -- sees a person with serious mental illnesses
9 having trouble, and so they can call and speak immediately to a
10 clinician. This is a live clinician that picks up the phone.
11 It is not an answering machine. It's 24 hours a day. You
12 speak with that person. A determination is made. And then, if
13 need be, the prescreener or the clinician will travel to where
14 that individual is.

15 Q Why were crisis services developed in Massachusetts?

16 A It's a hallmark of community-based -- comprehensive
17 community-based services that support individuals with serious
18 mental illness in the community. You have to have that. By
19 nature of the illness that it is a chronic illness, and people
20 do -- they get challenged by their symptoms periodically and
21 they need help.

22 And oftentimes, as I said, it could be a warm line where
23 they just call and chat. But maybe they need more. And then
24 you want to be available to them to divert them from the
25 hospital, stabilize them, and connect them back.

1 Excuse me. And it's good for family members, too, to be
2 able to access those services.

3 Q What happens if a mobile crisis team is called in and an
4 individual is in a potentially dangerous psychiatric situation?

5 A Well, the first thing that you do -- and I can speak from
6 personal experience -- is that when you get a call, the first
7 thing you do is get the contact information, where they are and
8 how you can reach them or how you can dispatch help to them,
9 because you may get disconnected, they may hang up, you may
10 lose service.

11 The next is to assess danger and immediacy of the problem.
12 And if you sense that there is a dangerous situation, you are
13 going to take the steps that you need to protect that person
14 and keep them safe.

15 For example, if it's a domestic violence situation, you may
16 send police. If there is a potential for someone harming
17 themselves, you are going to send your prescreener, maybe
18 police, maybe an ambulance. You are going to send who needs to
19 go there to help that individual. But always with the
20 prescreener or the clinician.

21 Q Turning back to your review in Mississippi, did you make
22 any conclusions regarding crisis services based on the people
23 you reviewed?

24 A I did.

25 Q What were your conclusions?

1 A It seemed that it was lacking. It seemed that there
2 were -- in reports I read, that there were crisis teams, but
3 when I spoke with individuals in my sample, it wasn't -- the
4 only way I can describe it is it wasn't part of the culture
5 where it wasn't automatically when you talk with someone, "Now,
6 you know you have the crisis number, you can get a live
7 clinician there any time. Take this card and put it on your
8 refrigerator. Here it is. This is a magnet, stick it in your
9 car." It wasn't that kind of a go-to information, because I
10 did ask individuals and their family members, "Were you told
11 about crisis? Did you use crisis? Were you aware of a crisis
12 number?" And it seemed to be lacking.

13 Q For the people you reviewed, could mobile crisis services
14 have prevented admission to a State Hospital?

15 A For a number of them, yes, I believe so.

16 Q How did you reach that conclusion?

17 A It was looking at the pattern of symptoms and how they
18 increased over time and that you could see in the record how it
19 was just getting worse and worse and worse. The individual was
20 not accessing crisis. The family members were not accessing
21 crisis.

22 I would ask when -- there was one individual I asked, "Did
23 you call the crisis line?" "No." You know, it just -- as I
24 said, it didn't seem to be a culture or a go-to, that this was
25 a hallmark of what you do, "We're here for you. We're going

1 to -- you know, you just call us and we will help you."

2 Q And is what you described different than your experience in
3 Massachusetts?

4 A Absolutely.

5 Q In what way?

6 A I mean, I can remember people calling the mental health
7 center and they would say, "I think I'm going to be in trouble
8 tonight." I mean, it would be during working hours and we
9 would say, "Well, come in right now or, you know, we'll send
10 your case manager out." "Well, I think I'm going to" --

11 THE COURT REPORTER: I'm sorry?

12 A People would call and say, "I think I'm going to be in
13 trouble after you close." And we would say, "Call the crisis
14 line. If you get in trouble, we're there." "Okay. Okay.
15 Good. Thanks. Bye." I mean, it was a given that they knew
16 about the crisis line and it was used, and it works.

17 BY MS. VAN EREM:

18 Q Can you give an example of a person that you reviewed in
19 Mississippi where a mobile crisis may have prevented a State
20 Hospital admission?

21 A I can. I would like to talk about person 117.

22 Q Okay. Can you briefly describe person 117's circumstances?
23 Page 203 of your report.

24 A This is a young man. He is 33 or was 33 at the time of the
25 interview. He is a father of young children. When we saw him,

1 he was living at his mother and father's home but he is someone
2 who is working full-time. We didn't go to see him until the
3 evening. He asked, because he is working during the day.

4 He is diagnosed with major depression and polysubstance use
5 disorder.

6 Q How many state hospitalizations did person 117 have?

7 A He had one.

8 Q How could mobile crisis services have prevented his
9 admission to a State Hospital, briefly?

10 A He is somebody that -- this individual before the State
11 Hospital admission had had a very serious suicide attempt, and
12 then just before this admission he had had a second suicide
13 attempt. The commitment was initiated by family, his sister.
14 And it was because he was becoming agitated, he was using
15 drugs, he has access to weapons, and the family was just so
16 fearful for him that they initiated a commitment.

17 Q So when was person 117's first hospitalization due to
18 symptoms of mental illness?

19 A That was in the summer of 2015, and that was to a community
20 hospital.

21 Q And was that in conjunction with his first suicide attempt?

22 A Yes. He took an overdose and he was on life supports.

23 Q Was he admitted to a State Hospital at that time?

24 A No.

25 Q What were the reasons for this -- sorry. Just one second.

1 What happened when he was discharged from the 2015
2 hospitalization?

3 A What happened when he was discharged?

4 Q In 2015. Yes.

5 A He was told that if he got in trouble again to call 911 or
6 to go to the ER or to come back. He had been in the medical
7 hospital first and then spent a couple of days at the -- at a
8 community psych unit. And when he left there, he was told if
9 you get in trouble again to call 911, go to the ED or come back
10 to that hospital.

11 Q Did you find any indications that person 117 had received
12 community-based crisis services after this 2015
13 hospitalization?

14 A No.

15 Q And when was person 117 hospitalized in the State Hospital?

16 A That was in the summer of 2017.

17 Q What had occurred immediately before that 2017 State
18 Hospital admission?

19 A His symptoms of depression had increased. He was agitated.
20 He was continuing to use drugs. He had -- about a week before
21 that, had a -- all suicide attempts are serious, but this one
22 was not as serious as the one in the summer of 2015. But he
23 had taken an overdose again and the family was very frightened
24 for him and so they initiated commitment.

25 Q Where did person 117 go after his family filed commitment

1 paperwork?

2 A He went to jail.

3 Q How long was he in jail?

4 A It was approximately a week, I would say the better part of
5 a week.

6 Q Had he been charged with any crime?

7 A No.

8 Q Turn to tab 1109 in your binder, the document marked
9 PX-1109. Is this a document you reviewed?

10 A Yes.

11 Q What is it?

12 A It is the South Mississippi State Hospital discharge
13 summary, and it's -- the admit date is 8-16-2017. Date of
14 discharge, 9-8-2017.

15 Q Did you rely on this record in reaching your conclusions
16 about person 117?

17 A I did. I took it into consideration.

18 MS. VAN EREM: I move to admit PX-1109 into evidence.

19 THE COURT: Any objection from the State?

20 MR. SHELSON: No, sir.

21 THE COURT: All right. PX-1109 will be received into
22 evidence.

23 (EXHIBIT PX-1109 MARKED)

24 BY MS. VAN EREM:

25 Q So turn to page 5 of this record. Will you please read the

1 paragraph that says, starts with "Follow-up Care"?

2 A "Follow-up Care: The patient is to follow up at Pine Belt
3 Mental Health in Mississippi, at 8:00 a.m. on 9-12-2017. The
4 patient is to follow up with his primary care doctor for any
5 medical issues as needed."

6 Q And will you also please read the last paragraph in this
7 document?

8 A "Instructions to Patient and Family: The patient and the
9 patient's family were educated on the patient's medication
10 regimen and the date and time of his follow-up appointments.
11 They were instructed in the importance of the patient taking
12 his medication as prescribed and keeping his outpatient
13 appointments. The patient and the patient's family verbalized
14 understanding of discharge instructions."

15 Q Was this record relevant to your findings?

16 A It was.

17 Q In what way?

18 A I'm finding the follow-up care and the instructions to the
19 patient and family as lacking, and there is really nothing in
20 here about crisis services. But I am also concerned that the
21 burden, the complete burden of affecting follow-up care is
22 placed on the patient and his family. Not only the psychiatric
23 part but the medical part as well. And this is a man who has
24 chronic pain, which was the beginning of his drug use to begin
25 with, was that he takes opiates for his pain or medication to

1 dull the pain.

2 And so even to place the burden both psychiatrically and
3 medically on him, it seems like healthcare providers have an
4 obligation to do more to help people connect.

5 Q Did you make any findings about whether person 117 is at
6 serious risk of hospitalization?

7 A I did.

8 Q What were your findings?

9 A He is. He is at risk.

10 Q In your experience, have people with similar severity of
11 serious mental illness as person 117 been safely served in the
12 community without being at serious risk of hospitalization?

13 A Absolutely. Did you want me to elaborate?

14 Q Sure.

15 A I mean, this is an individual -- and I have known
16 individuals in my experience very similar to this young man.
17 He has, as he verbalized, a lot to live for. He has young
18 children. He wants to stay involved in their lives. He has
19 hobbies, he has a job, he has goals, and he is someone who is
20 very interested in getting well, which he talked about the
21 plans that he has for that.

22 However, he has challenges. He has chronic pain. He has a
23 history of drug use and he also has a history of depression.

24 Q What services would person 117 need to be safely served in
25 the community?

1 A The crisis services first and foremost. And that would be
2 24-hour a day availability of a clinician. The range that I
3 discussed previously, both available to the individual, also to
4 his family members. I spoke at the time of the interview with
5 his mother, and she was very concerned about how they can help
6 their son.

7 The other thing that's important for him is to connect him
8 with recovery services. He has a substance use disorder. To
9 be connected with a 12-step program and a sponsor. And he is a
10 veteran. And so it would be appropriate for him to be
11 connected with veteran services. So through that, to have a
12 case management function, either through a sponsor or through
13 the veteran service, would be appropriate for him.

14 Also, he would need connection with a psychiatric
15 prescriber. He is somebody who at this point wants to wean
16 himself off medication but at least to have that relationship
17 if need be, and connection, as I said before, to the medical
18 because of his chronic pain.

19 Q Did person 117 receive those services in the community?

20 A He did not. The other piece is benefits assistance for
21 him. I would add that.

22 Q And we will go into this a little bit more later but what
23 is benefits assistance?

24 A To help people obtain the -- the ability to pay for their
25 healthcare. It can be -- for this individual, it might be

1 through the Veterans Administration, but also for people to
2 obtain healthcare insurance or to get on a disability insurance
3 or whatever is appropriate for them to help them pay for not
4 only their psychiatric treatment, community-based services, but
5 their medication.

6 Q Did person 117 receive any community-based mental health
7 services?

8 A He had been referred for outpatient groups and to meet with
9 a nurse and to receive medication in the community, and he --
10 he went for a while but he stopped for a variety of reasons
11 that he talked with me about.

12 Q What were some of those reasons?

13 A He does not have transportation so it was hard to get
14 there. He worked, so he would need appointments that were in
15 the evening or on the weekend. He also was very concerned that
16 he had to pay for the visits. He said the visits are \$25 a day
17 and he is having trouble affording that, which is also
18 something his mother talked about.

19 And that to be -- I didn't -- in my opinion, the services
20 he was referred to were not the best services for him. He
21 doesn't want to take medication. So to refer him for a
22 medication and tell him yes, to take it, or to be in groups may
23 not be appropriate for him. There was nothing with regard to
24 his substance use disorder either.

25 Q What happened when he stopped going to outpatient

1 treatment?

2 A The first time or the second time?

3 Q You mentioned that he had been going to some outpatient
4 appointments but stopped going.

5 A I would have to say that he just has been kind of on his
6 own since then. He is weaning himself off medication.

7 Q And did the community mental health center reach out to him
8 when he stopped going to his appointments?

9 A I asked about that, and he said, "If I miss an appointment,
10 they will send a letter or they will call." But it's not
11 their -- they have left messages or they send the letter. It
12 is not that they've talked with -- he said he hadn't talked
13 with them directly.

14 Q Based on your experience, would you expect a different
15 approach, given person 117's history?

16 A I would. I would expect a more hands-on approach with
17 someone like this individual. He has had two suicide attempts
18 within the past three years, and he has major depression, he is
19 a substance use disorder person. He is -- he has some high
20 lethality risk. I would want to stay very much on top of him.
21 I would want a case management function to be very much aware
22 of how he is doing all the time.

23 Q What do you mean by high lethality risk?

24 A That he is someone who could enter into that same situation
25 that he was in in summer of 2015 or in 2017 where he becomes

1 depressed, he starts using drugs, and he takes another
2 overdose.

3 Q What effect could crisis services have had on person 117?

4 A The 24-hour capacity is important because that would be
5 accessible both to his family. If the individual didn't call,
6 then the family could call. But just to say, "We're worried
7 about our son." Or his girlfriend could say, "I'm worried
8 about the father of my children. I want someone to see him. I
9 think he is using again, I'm not sure." You know, and to get
10 in front of the symptoms and to get connection right away in
11 this case to keep him safe but also to avoid any further
12 hospitalization. It's the appropriate care for this individual
13 with these symptoms.

14 Q You mentioned benefits assistance and I would like to go
15 back to that a little bit. In your professional experience,
16 should benefits assistance be provided to people with serious
17 mental illness?

18 A Absolutely.

19 Q Why?

20 A Well, in the case of this individual, and there were
21 several other, where they did not have -- oftentimes when
22 people have serious mental illness, they have trouble
23 organizing their thoughts or planning what they need to do in
24 an organized way. So to apply for healthcare benefits on their
25 own can be challenging. And so to have someone help with those

1 applications or those interviews or providing the documents,
2 the proof needed, to have coverage for your medication. I had
3 one individual who was not able to obtain his medication
4 because -- his shot, his intramuscular shot, because he didn't
5 have his insurance in place.

6 Q Who should provide benefits assistance?

7 A It can be provided by a number of individuals. But,
8 appropriately, the case manager can help.

9 Q Does the hospital have a responsibility to provide benefits
10 assistance?

11 A Absolutely. The social worker in the hospital is an ideal
12 person for that role.

13 Q How could benefits assistance have affected person 117's
14 risk of hospitalization?

15 A If he had benefits in place, and it is something that he
16 says he wants to have, that he is working but he is not sure
17 how he could even get it through his work, he has heard stories
18 from coworkers about how to get it, but in this case he
19 wouldn't have to pay for his visits, which he said was a
20 deterrent to him going to the visits, it's \$25 out of pocket.
21 So it might have helped him get more connected with the mental
22 health center if he had insurance to support that.

23 And then I would see the mental health center, once the
24 connection is made, helping him with those other services that
25 I discussed previously.

1 Q Did you find that benefits assistance may have prevented
2 unnecessary hospitalization for other individuals in your
3 review?

4 A I did.

5 Q Going back to crisis services, did the lack of access to
6 crisis services lead to unnecessary hospitalization for any
7 other individuals you reviewed?

8 A Yes.

9 Q Can you provide another example?

10 A I can. I would like to talk about person 108.

11 Q Can you tell us a little bit about person 108? It is on
12 page 150 of your report.

13 A This is a very young man. At the time of the interview, he
14 was 27 years old. He had been in -- had eight State Hospital
15 admissions in the past nine years.

16 When I saw him -- I'm just going to get on my page here --
17 he was living with his grandmother, and the grandmother was
18 very knowledgeable about his illness and very in touch with
19 what his symptoms are.

20 He has, I would say, an underlying symptomatology at all
21 times that he is struggling with. And with the support of his
22 grandmother, he is managing. He was -- I will just say briefly
23 he is delightful. He is very interested in sports and he could
24 talk about basketball and baseball forever. You know, it was a
25 very animated discussion.

1 Q You mentioned the term "underlying symptomatology." Do you
2 mean that he experiences symptoms most of the time?

3 A Yes. Yes.

4 Q What typically triggers person 108's hospitalization?

5 A His description and the grandmother's description is he
6 becomes -- particularly in the wintertime when it's dark, he
7 becomes isolated, he is not able to go out as much. He is
8 always struggling with these symptoms. He has a fixed
9 delusional system about there has been a lot of losses in the
10 family and he somehow in his delusion believes that he could
11 prevent these if he could learn more about who or what is
12 making them happen. So he becomes isolated and the symptoms
13 increase. He goes in his bedroom, he tries to drown out the
14 voices and the thoughts, and he can't.

15 Q Why did you find that crisis services could have prevented
16 unnecessary hospitalization in person 108's case?

17 A Because he has a lot of strengths. He is someone who is
18 very -- he has a good deal of insight into his symptoms. And
19 his grandmother -- he lives with his grandmother who is a
20 tremendous support. And the 24-hour crisis services would
21 offer a contact for them when these symptoms start increasing.
22 And the grandmother could call and say, "I would like someone
23 to come visit my grandson and talk with him and figure out
24 what's going on." He might call and talk with the hot line or
25 he might talk with a clinician.

1 And if symptoms were continuing, he might even -- it would
2 be appropriate for him to have a stay at crisis stabilization,
3 get connected on maybe a higher dose of medication temporarily,
4 have someone to talk to, feel in a safe place.

5 Q Did person 108 receive those crisis services?

6 A No. It was not indicated in the record.

7 Q Could crisis services have prevented his last admission to
8 the State Hospital?

9 A I believe so. And the others as well. He has had a number
10 of them at such a young age.

11 Q In your professional experience, have you seen people like
12 person 108 able to be served in the community without repeated
13 hospitalizations?

14 A I have. I have.

15 MS. VAN EREM: Your Honor, I'm getting close to the
16 end but I maybe have I would estimate about 20 to 30 minutes
17 left. I'm not sure if you would like to take a lunch break now
18 and then I can wrap up after lunch or if I should keep going.

19 THE COURT: You should keep going. I mean, we will do
20 our cross-examination after lunch.

21 MS. VAN EREM: Okay.

22 BY MS. VAN EREM:

23 Q Dr. Baldwin, did you make any findings regarding state
24 hospital discharge practices?

25 A I did.

1 Q What were your findings?

2 A I have kind of mentioned it before but I can say I did not
3 see the discharge planning taking place right at the point of
4 admission, which is standard practice. I did not see the
5 inclusion of the individual or their informal support network
6 involved in discharge planning as much as -- as I thought it
7 should be, given my experience.

8 And, also, I didn't see the transition kinds of activity
9 between the hospital and the community mental health center
10 that is proven to be successful. And I can describe that
11 activity if you want or --

12 Q Sure. If you can briefly describe the transition activity.

13 A To have the community mental health center involved right
14 from the beginning, that staff or the case manager or other
15 staff that would be working with that patient, come to the
16 hospital, meet with the patient, meet with hospital staff,
17 participate in meetings, and so that the individual has a
18 familiar face that when they go out, they know they have
19 already made a connection with that person. And to start right
20 at the beginning, shared records. There is all kinds of ways
21 that a transition phase can take place.

22 The other thing that I saw is oftentimes with individuals,
23 they would be in the hospital for a while, they would be
24 stabilized, and at that point the discharge planning would take
25 place. So it would mean that a person is -- has very few

1 symptoms and yet they're still in the hospital waiting to be
2 discharged.

3 Q And to be clear, that's what you saw in Mississippi in your
4 review?

5 A I did.

6 Q What was the effect of this inadequate discharge planning?

7 A People ended up staying in the hospital longer. The
8 connections were not made with the community-based services as
9 would effect a successful discharge. And so the person would
10 come out of the hospital and they may or may not connect with
11 the community-based services because it's difficult at that
12 point.

13 Q And then what would happen if there was --

14 A Then they would go back into their pattern of an
15 exacerbation of symptoms, no one to connect with, and then end
16 up needing a higher level of care.

17 Q And by higher level of care, are you referring to
18 hospitalization?

19 A A hospitalization, yes.

20 Q Are there any examples of people you reviewed who did not
21 receive an adequate discharge planning process?

22 A There are. I can talk --

23 Q Will you share one example?

24 A I can talk about person 92.

25 Q If you will please briefly describe person 92. It's on

1 page 35 of your report.

2 A This is a young woman. She is 30 years old. I'm just
3 going to get to my page. She has had six hospitalizations to
4 the State Hospital, according to the record. She is someone
5 who is diagnosed with substance use disorder but also
6 schizophrenia. She is someone who has lived independently on
7 her own. At this point she is in a program out of state.

8 Q What is your basis for saying that person 92 did not
9 receive an adequate discharge planning process?

10 A Well, I reviewed her hospitalizations. I also spoke with
11 her and I spoke with her mother as well. And with the six
12 hospitalizations -- and again, she is 30 years old, so, you
13 know, they have all taken place recently from a young adult to
14 present. The first two, there was no indication of any
15 discharge planning. There was no aftercare plan for her,
16 according to the records from the State Hospital.

17 The third one, she was discharged to her grandfather, and
18 the grandfather was tasked with connecting her with another
19 family member out of state. So no discharge planning there.

20 The fourth one, it was all aftercare service, were simply
21 referred to the -- what is it called, the CR -- the
22 residential, central residential program. So the program was
23 tasked with all the aftercare services, so there was nothing
24 specific there.

25 The fifth one, she was discharged to a man, an older man

1 who had lied twice about his relationship with her, and
2 ultimately it was found, per the mother's report in the record,
3 that he is in prison and he had been exploiting her,
4 prostituting her, giving her drugs. So that was the fifth
5 admission.

6 The sixth, she was discharged, and that was at that point
7 when she went to Ohio to live, and her mother was tasked with
8 getting her into a program in Ohio, which is where she is now.
9 So there was no planning for that one either, just discharged
10 to the mother.

11 Q How did person 92's discharge planning process differ from
12 professional standards?

13 A In my opinion, the best discharge planning is, again,
14 taking place from the point of admission. It's involving the
15 individual and the family member but also making those
16 connections for that individual, and the individual meeting
17 people who are going to be treating him or her in the community
18 and not tasking family members with the full burden of the
19 discharge -- the aftercare planning and the connection with
20 community services.

21 Q How did person 92's discharge experience affect her?

22 A She cycled back into the hospital six times because there
23 was no connection. This last time she had been three weeks
24 living in woods behind Walmart. She had been homeless. The
25 time before that, as I said, she had been exploited and had

1 been prostituted.

2 So the connections within the community for her substance
3 use disorder and also her serious mental illness were not being
4 treated at all.

5 Q Dr. Baldwin, do you have any other examples about
6 individuals who have experienced unnecessary hospitalization
7 that you would like to share with the court today?

8 A I can talk about person 91.

9 Q If you can tell us a little bit about person 91. It starts
10 on page 27 of your report.

11 A Person 91 is a 59-year-old African-American man. On the
12 day that I saw him, he came to meet us in a meeting room at
13 Jaquith Nursing Home. I'm sorry. I want to find the beginning
14 here.

15 Q Sure.

16 A He has had a total of 17 admissions to State Hospital. And
17 he is a double amputee. He came to us in a wheelchair that was
18 being pushed by someone else, but he had shared with us that
19 his own wheelchair, where he is able to mobilize, had been
20 taken away from him, he didn't have that.

21 He was, again, a very animated person, very upbeat, very
22 wanting to talk with us about his strong desire to leave the
23 nursing home. And we talked a lot about his hobbies and his
24 interests and his desires.

25 Q You mentioned the nursing facility. Is Jaquith Nursing

1 Facility associated with the State Hospital?

2 A It is associated, I believe, and it is on the grounds of
3 the State Hospital. I know when I see physical exams of the
4 patients, it's on Jaquith stationery, so I think they do the
5 physical examinations for patients.

6 Q You mentioned person 91 talked to you about his hobbies.
7 What does he like to do?

8 A He is a musician, and he has played in Chicago in all the
9 blues places. He talked about other musicians. He loves to
10 improv, improvise. He plays a saxophone. He plays a
11 harmonica. He plays clarinet or he wants to learn clarinet.
12 He is very interested in music. He has been his whole life.

13 Q Was he able to play the saxophone during his most recent
14 admission to the State Hospital?

15 A He had asked for a saxophone and I had interviewed his
16 friend who confirmed that he brought his saxophone to the
17 hospital. But for some reasons, he was unable to play it
18 without some adaptations, so the saxophone was locked up for
19 safekeeping. That's what the record said. So he never was
20 able to play it, unfortunately, although he wanted to.

21 Q What were the reasons for his most recent admission to the
22 State Hospital?

23 A He had been living in a nursing home and he is very -- he
24 is a strong personality, as I described, and his brother
25 described him that way, as his friend did as well. And he

1 likes to smoke cigarettes. He likes to make his own decisions
2 and be as independent as possible, and the nursing home was not
3 allowing him to smoke his cigarettes. And so over time he got
4 increasingly more agitated and more agitated and got engaged in
5 some bizarre behavior around wanting to smoke, and ultimately
6 the nursing home initiated the commitment process.

7 Q How long did this most recent admission last? I think it's
8 on page 30.

9 A He came in in June of 2015, and he did not leave until
10 March 2016. So he was there quite a long time.

11 Q Did you make any findings regarding whether person 91 could
12 have avoided or spent less time in State Hospitals?

13 A Absolutely. This is someone who has cycled in and out of
14 State Hospitals 17 times over his life, and that the aftercare
15 services that could be available to him in the community were
16 not being provided.

17 Q So to clarify, did you find that he could have avoided or
18 spent less time in State Hospitals?

19 A Yes.

20 Q During his most recent admission, did person 91 want to be
21 in a State Hospital?

22 A Oh, no. He was very adamant about wanting to leave. He
23 talked with us at length about it. And, also, it was
24 documented in the records frequently how he wanted to leave.
25 He had shared that he agreed to a nursing home because he

1 thought it would be a stepping stone to the community and to
2 his own apartment. He thought it would be easier to get out of
3 the nursing home than to get out of the State Hospital.

4 Q If you'll turn to tab 1110 in your binder, document marked
5 PX-1110. Is this a document you reviewed? It's also on the
6 screen.

7 A Yes.

8 Q What is this document?

9 A This is a Mississippi State Hospital clinical progress
10 note. It's a psychology weekly note and it's dated July 7th,
11 2015.

12 MS. VAN EREM: Your Honor, I move PX-1110 into
13 evidence.

14 THE COURT: Any objection from the State?

15 MR. SHELSON: No, Your Honor.

16 THE COURT: PX-1110 will be received into evidence.

17 (EXHIBIT PX-1110 MARKED)

18 BY MS. VAN EREM:

19 Q Can you read the highlighted portion of this record,
20 Dr. Baldwin?

21 A I can. "No significant behavioral problems noted during
22 the review period. Person 91 was observed as being calm and
23 cooperative in the milieu. He was generally seen rolling his
24 wheelchair in the hallway or different areas of the building.
25 Mood appears stable with no signs of aggression or anger

1 observed or reported. He continues to deny SI," suicidal
2 ideation, "homicidal ideations. He continues to have limited
3 insight and awareness into his condition, AEB" -- or as
4 evidenced by -- "stating, *I don't know why they put me here.*
5 *I'm just ready to leave here. This is like a prison.*"

6 Q Dr. Baldwin, what did you conclude from looking at this
7 record?

8 A It's very similar to the way I saw him, the way he
9 presented, that there was no evidence of exacerbation of
10 serious mental illness symptoms. He was calm. He -- his mood
11 appeared stable, no anger or aggression. Absence of symptoms.
12 He has never expressed any suicidal or homicidal ideations.
13 That's not part of his symptomatology.

14 And the part that was concerning to me is he continues to
15 have limited insight and awareness into his condition by
16 stating, "I don't know why I'm here, I'm ready to leave,"
17 whereas I don't see that as limited insight. He is talking
18 about what his goals are. He wants to leave and he wants to be
19 more independent.

20 And the answer, if I just -- one more thing. The response
21 to that is simply, "I will continue to monitor and assess
22 patient progress." There is no intervention based on that,
23 saying, "Well, let's talk more about what your goals are," or
24 "You seem to not be having any symptoms right now. Let's take
25 the next step." That's not there.

1 Q How much longer was he in the State Hospital after this
2 progress note was written?

3 A Well, that was in July 2015, and so he did not leave
4 until -- and I've got to find it again so I can tell you
5 exactly.

6 Q I think it's on page 30.

7 A He didn't leave until March 2016. So that's several months
8 prior.

9 Q If you will turn to tab 1111 in your binder, document
10 marked PX-1111. Is this a document you reviewed?

11 A It is.

12 Q What is it?

13 A It's Mississippi State Hospital clinical progress note, and
14 it is the Social Service weekly note, and it is dated
15 August 7th, 2015. There is no treatment plan problem number
16 there, so that's absent.

17 Q Can you please read the highlighted portion?

18 A "Person 91 met with SW," or social worker, "several times
19 this week. He let social worker know that he has been praying
20 to God and that he is helping to carry him through. Person 91
21 asked social worker, or SW, each day about going home. SW
22 explained to him that he is not quite ready for discharge but
23 that if he continues to go to his groups and comply with his
24 medication, when he is ready, social worker will refer him for
25 placement."

1 MS. VAN EREM: Your Honor, I move PX-1111 into
2 evidence.

3 THE COURT: Any objection from the State?

4 MR. SHELSON: No, sir.

5 THE COURT: PX-1111 will be received into evidence.

6 (EXHIBIT PX-1111 MARKED)

7 BY MS. VAN EREM:

8 Q Dr. Baldwin, did this record contribute to any of your
9 conclusions?

10 A It did.

11 Q In what way?

12 A It supports the way he talked with me in the interview,
13 also with other notes in the record, that he is continuously
14 asking and, in this case, each day, about going home and that
15 he is feeling -- I am interpreting from this that he is praying
16 to God that he is helping him to get through this, trying to be
17 patient.

18 But the other part that was concerning to me is the social
19 worker is saying, "You are not ready for discharge, but if you
20 behave or you go to your group," she doesn't -- that's my word,
21 "behave," continue to go to your groups and comply with
22 medication, when he is ready, social worker will refer him. He
23 is saying he is ready now. And so that's not what the social
24 worker is doing. And she is looking or he is looking for
25 nursing home placement as the best option.

1 Q We have one more document. So if you'll please turn to
2 tab 1112 in your binder, the document marked PX-1112. Is this
3 a document you reviewed?

4 A Yes, it is.

5 Q What is this document?

6 A This is Mississippi State Hospital clinical progress note,
7 and this is dated September 2nd, 2015. And it is a Social
8 Service weekly note.

9 MS. VAN EREM: Your Honor, I move PX-1112 into
10 evidence.

11 THE COURT: Any objection from the State?

12 MR. SHELSON: No, Your Honor.

13 THE COURT: PX-1112 will be received into evidence.

14 (EXHIBIT PX-1112 MARKED)

15 BY MS. VAN EREM:

16 Q Dr. Baldwin, can you please read the highlighted sentence?

17 A "He does not specify what is bothering him but he continues
18 to say, *I got to get out of here -- or "her,"* but that's a
19 typo -- *got to get out of here; these people treat me like a*
20 *child.*"

21 Q Okay. And can you read the next highlighted portion as
22 well?

23 A "Person 91 initially asked SW or social worker for boots
24 when he was admitted, but after a few weeks he stopped asking.
25 This week person 91 asked social worker to get him a sixe" -- a

1 size, that's a typo -- "size 10 tennis shoe so that he can wear
2 them on his stumps. Person 91 does not seem to realize that he
3 can't walk on his stumps. When social worker told him that he
4 couldn't have tennis shoes for his stumps, he noted, *I will get*
5 *some when I get out.*

6 Social worker let him know that that was an indicator that
7 he was not ready to leave and he started speaking in a whining
8 voice as if he were crying and said, *Y'all ain't gone never let*
9 *me out of here.* Social worker tried to explain to him that he
10 would be discharged when he was ready, but he did not want to
11 listen to reason."

12 Q Dr. Baldwin, did this record contribute to any of your
13 conclusions?

14 A It did.

15 Q In what way?

16 A It is -- I am very much aware that people with -- are
17 double amputees. There are some people who have long leg
18 prosthesis. Other people prefer to walk on their stumps. They
19 have special shoes that allow them to walk on their stumps.
20 Some people have even had skin grafts to allow the skin to be
21 tougher on the stumps. And this individual has a history of
22 walking on his stumps, which he talked to us about. And yet
23 here -- and it is also in other parts of the record as well,
24 his wanting to get out, wanting to walk on the stumps is being
25 viewed by staff as an indicator that he is not ready to leave,

1 when, in fact, he is asking to go and he is asking to have a
2 way to be more independent so that he can ambulate.

3 Q In your experience, have you served individuals with
4 similar levels of severity as person 91 in the community?

5 THE COURT REPORTER: I'm sorry?

6 BY MS. VAN EREM:

7 Q Have you served individuals with similar levels of severity
8 of serious mental illness as person 91 in the community?

9 A I have.

10 MS. VAN EREM: Your Honor, if I may just have a brief
11 moment to confer?

12 THE COURT: Yes, you may.

13 (SHORT PAUSE)

14 BY MS. VAN EREM:

15 Q A couple more questions. Dr. Baldwin, you previously
16 testified that the burden of ensuring an individual stays
17 connected to community-based services should be shared between
18 the individual and mental health providers. Is that right?

19 A Correct.

20 Q Do individuals with serious mental illness have difficulty
21 staying connected to treatment on their own?

22 THE COURT REPORTER: I'm sorry.

23 MS. VAN EREM: I'm sorry.

24 BY MS. VAN EREM:

25 Q Do individuals with serious mental illness have difficulty

1 staying connected to treatment on their own?

2 A In general, yes. And I had testified earlier that there
3 is -- it's challenging oftentimes to organize thoughts, to plan
4 ahead, to think about having an appointment, writing an
5 appointment, getting yourself there, navigating the waiting
6 room or an auto attendant on a phone. Those are all challenges
7 to stay connected.

8 Q Why are those challenges specifically for people with
9 serious mental illness?

10 A Because they have -- in general, it is an executive
11 functioning or it is a piece of the brain that often has
12 trouble organizing. I mean, I think, you know, I can speak for
13 myself, I have trouble organizing sometimes remembering
14 appointments, and they do. It also is a trust issue, to be
15 able to build a relationship with someone to connect with them
16 so that you can receive your services and continue to do that.
17 So people with serious mental illness have those challenges.
18 They also may have paranoia or suspicion where it is hard for
19 them to connect with anyone. They tend to be isolating
20 themselves.

21 Q And how can community providers help people stay engaged in
22 community-based treatment?

23 A The range of community-based services are -- each and every
24 one is very important. Some may be more important for some
25 individuals, a PACT team, a case manager, connection to a

1 psychiatric prescriber, 24-hour --

2 THE COURT REPORTER: I'm sorry.

3 THE WITNESS: That's okay. Where did I go too fast?

4 A A case manager, connection to a psychiatric prescriber,
5 connection to primary care for their co-morbid medical, a
6 connection to substance use treatment if that's needed. And
7 all of these services to a greater or lesser degree are going
8 to be very effective in supporting people in the community.

9 BY MS. VAN EREM:

10 Q Thinking back on your review, do you have any lasting
11 impressions from your experience doing the review in
12 Mississippi?

13 A I do. I have included in my assessments before this, this
14 particular project, throughout my whole career, when I meet
15 with people, I ask them about their three wishes. And so I was
16 glad that it was included in this interview where we would ask
17 people about their three wishes, because it gives them an
18 ability to imagine, to step outside of their situation. And
19 then it's the foundation of goals.

20 Q And when you say their three wishes, do you mean if you had
21 three wishes, what would they be? That question?

22 A "If you had three wishes, what would they be?" And to just
23 think about that. And people would, for the most part, give me
24 those three wishes that they would -- they would think about it
25 and then they would provide the three wishes. And the

1 foundation of recovery in serious mental illness is to have
2 goals, to have your own goals. And so to develop goals, you
3 can start with wishes. And then the wishes themselves were --
4 their wishes were things like, "I would like to live in my own
5 house," or "I would like to have enough money to do the things
6 I want to do," or "I would like to be close with loved ones."
7 And when you think about it, those are the wishes we all have.

8 MS. VAN EREM: I have no further questions at this
9 time.

10 THE COURT: Okay. All right. It is appropriate for
11 us to take our lunch break at this time. It's about 12:46.
12 Let's start back up at 2:05.

13 And, Dr. Baldwin, you may step down and we'll begin
14 your cross-examination at 2:05.

15 THE WITNESS: Okay.

16 THE COURT: All right. Thank you.

17 *(Lunch Recess)*
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1 CERTIFICATE OF REPORTER
2

3 I, BRENDA D. WOLVERTON, Official Court Reporter, United
4 States District Court, Southern District of Mississippi, do
5 hereby certify that the above and foregoing pages contain a
6 full, true and correct transcript of the proceedings had in the
7 aforementioned case at the time and place indicated, which
8 proceedings were recorded by me to the best of my skill and
9 ability.

10 I certify that the transcript fees and format comply
11 with those prescribed by the Court and Judicial Conference of
12 the United States.

13 This the 12th day of June, 2019.

14
15 s/ Brenda D. Wolverton
16 U.S. DISTRICT COURT REPORTER
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